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ORIGINAL DEPARTMENT.

COMMUNICATIONS.

ANTISEPTIC SURGERY.*

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The subject assigned me by the society at its former meeting opens such a broad field for discussion that it is difficult for me to mark out any path in which to travel.

To attempt to give a detailed history of Listerism, or its offspring, antiseptic surgery, would be too onerous an undertaking—burdensome to myself, and tiresome to you. To attempt any description of the minutiæ of Listerism would be a work of supererogation—a presumption on my part that the members of this society do not keep posted upon the current medical literature of the day.

Without attempting either of the things mentioned above, a rapid resumè of Listerism, with what it has accomplished, and some deductions therefrom, will be permissible, and may perhaps interest and profit us.

Of course, we all recognize the fact that in antiseptic surgery, as taught by Lister, putrefactive changes result from the development of the lower order of animal or vegetable life (bacilli) in open or imperfectly closed wounds. It is needless for me to undertake to name the bacilli, or to differentiate their modus vivendi. Suffice it to say that antiseptic surgery in its incipiency was founded upon the idea of existence of these parasites, and the necessity for their exclusion from contact with wounded tissue.

*Read before the Gibson County Medical Society, December, 1884.

An illustration of the modus operandi of Listerism is shown in simple fractures, with the consequent contusion and laceration of the adjacent tissues. So long as there is no laceration of the cutis, so as to admit air to the wound; so long as the fracture is not a compound one, the surgeon anticipates no trouble. He looks forward to a steady and progressive cure, assigning, with some degree of certainty, a time when the patient will be able to use the damaged member. In this case there is no nidus for the development of animal or vegetable parasites. Nature has interposed an antiseptic shield between the air and the damaged tissue. Acting upon this idea as one step, Lister developed the further idea that it was "essential in treating a wound to destroy all forms of animal or vegetable life (bacilli) floating in the air of the room, to destroy all that had obtained lodgment in the wound, and then to prevent the entrance of more; that the wound, after being dressed, should never be opened or redressed except under the same favorable conditions."

We all know how the carbolic spray and antiseptic gauze, etc., etc., were used to accomplish this result; how the air was surcharged with carbolic spray; how the spray was kept playing upon the part operated on; how all the instruments were kept immersed in a solution of carbolic acid of a certain definite and fixed strength: how it was required that the finger-nails of the operators be trimmed, cleansed and carefully soaked in the antiseptic lotion, and the hands and faces of all present subjected to a careful disinfection; how no one could wear clothes at an operation in which he had visited other sick; how, in fine, all of the surgical world became mono-

maniacs on the subject of Listerism. Most brilliant successes were reported, where operations of the greatest magnitude had been performed, followed by recovery of the patient, without any acceleration of the pulse, or any rise of temperature; where all the discharges from the wound had been pure, fresh, and sweet. No one reported for a long time anything but favorable results. Where a case died, the death was attributed to some fortuitous circumstance entirely disconnected from the operation.

But a reaction began. Cases would terminate fatally, in spite of the new gospel of Listerism. More careful surgeons, upon investigation, found the urine smoky, and other symptoms of carbolic acid poisoning present. Finally it became an admitted fact that patients would die from carbolic acid poisoning in antiseptic operations.

A reaction set in, and an attempt was made to prove that antiseptics were dangerous. The fact, however, that the imprudent use of carbolic acid resulted in some deaths could not upset a procedure that had shown such brilliant results. Surgeons continued their investigations to discover safer parasiticides. Benzine, creasote, turpentine, eucalyptol, bichloride of mercury, and a host of other things, were used, all having a common hostility to animal and vegetable life. One surgeon used one, another another. The two that have retained the strongest hold upon the profession have been carbolic acid and corrosive sublimate.

Carbolic acid was claimed to present the following as some of its main advantages: A solution of one to forty was considered sure destruction to bacilli; it was a local anæsthetic; it was cheap, and hence in the reach of all. The villainous odor of the impure acid has been almost entirely removed, leaving in its stead, in the pure acid, only the carbolic smell. This odor always speaks for itself, and hence prevents the solution being mistaken for anything else. The advocates of bichloride of mercury claim that a solution of the strength of one to two thousand is a better parasiticide than anything else; that used in the form of spray in any operation, it is absolutely harmless, etc., etc.

And so I might go on and enumerate the advantages and disadvantages of each of the agents advocated by different surgeons. The process of Listerism finally became a mysterious science, fully understood only by the one using, and then only in his own peculiar way. As to the results following its use, in later years most contradictory reports have been made. No one will question the statement that surgeons, emboldened by the success of Listerism, have ventured to perform, and have successfully performed, operations that they would not have undertaken a few years ago. The abdomen has been opened thousands of times, and many valuable lives saved in what had been considered hopeless cases. Take, for instance, Langenbeck's and Billroth's cases of gastrostomy for cancer of the pylorus, where they successfully removed a portion of the stomach and duodenum to eradicate the disease. The stomach has been opened and strictures of that viscus stretched, and foreign bodies removed therefrom.

The abdomen has been opened in cases of gunshot wounds, bullets removed therefrom, and lesions of the intestines repaired by suturing—in some cases many inches of the bowel having been removed. Portions of the lung tissue have been exsected; and so I might enumerate many other operations done under the stimulus of Listerism.

Prof. von Nussbaum, in summing up the results of antiseptic surgery, says that the mortality among cases treated antiseptically is much less than among those treated according to the old plans of dressings. In his surgical clinic, the death-rate had been reduced one-half since the introduction of antisepsis. Cases of severe wounds, that formerly suffered much from fever of several days' duration, under his new management suffering scarcely at all. Head injuries that formerly contracted erysipelas and frequently died from secondary meningitis, healed in a few days without complications, and the mortality had fallen to almost nil. (*Edinburgh Med. Jour.*, May, 1881.)

In strong contrast to the results obtained by Nussbaum, Dieffenbach, a bold German operator, wrote, only so far back as 1842, "It is unjustifiable to cut into the abdominal cavity in order to take out a diseased ovary. The organism will not tolerate such interference." Dieffenbach had been dead only a few years, when splendid results began to be obtained in England from ovariotomies. A modest calculation shows that through ovariotomies performed in England, France, and Germany, more than 30,000 years of life have been added to the human race. That which was termed by Carl Theodore Merren "a beautiful dream of youth," viz., to remove a cancer of the stomach, has come to pass, and not only that, but Prof. Czerney has demonstrated practically that a person can live after the whole stomach has been removed, he having cut out the whole stomach, and stitched the œsophagus to the duodenum.

Further, as to some of the results of Listerism or

antiseptic surgery: On page 729 of Dr. Thomas's work on Diseases of Women, 4th edition, we find a tabulated statement of 1653 operations for ovariotomy performed by many different surgeons, without the spray or antisepsis as now understood, with 528 deaths, a mortality of 32 per cent. In the *St. Louis Courier of Medicine*, June, 1883, I find a letter from I. Knowsley Thornton, in which he reports 171 antiseptic ovariotomies, with 10 deaths, a little more than $5\frac{3}{4}$ per cent., and, in the same letter, 114 operations where antiseptics were not carefully used, with 20 deaths. In 300 ovariotomies with antiseptic precautions, Mr. Thornton's average mortality was only 8 per cent. Mr. Keith had 80 successive recoveries under Listerism, whilst in that 100 cases (including the 20 which followed the 80) he lost 5, but three of the five were from carbolic acid poisoning. I might devote page after page to comparative statistics, such as the above, without profit to this society, but suffice it to say that the reduction of the rate of mortality would be shown to be barely as great in all. I chose ovariotomy, because the statistics have been carefully kept.

Many of the best surgeons have refused to adopt Listerism in all of its details, and claim equally as good results from the most scrupulous cleanliness, aside from and without the spray. Mr. Keith, after using the spray, abandoned it, because he lost several cases from carbolic acid poisoning under its use. Mr. Lawson Tait has never used the spray. Dr. George J. Englemann, in a letter written from Vienna, and appearing in the St. Louis *Courier of Medicine*, November, 1882, says that the spray is being abandoned, and that cleanliness more that antisepsis is looked to; still, in their dressings, carbolic acid, salicylic acid, and iodoform, are extensively used. Billroth formerly used the spray, but abandoned it prior to 1884, laying greatest stress on cleanliness both before and after the operation.

Dr. Goodell, Prof. Eric, and Dr. Thomas, of our own country, all use the spray. Dr. Gross was no believer in Listerism, but was firmly persuaded that antisepsis in the form of cleanliness was the great essential in surgery. In an article in the *Quarterly Epitome*, March, 1884, I find statements containing the following ideas: "It is argued that germs (bacilli) cause septicæmia; antiseptics destroy germs; the use of antisepsis has been followed by good results, and, therefore, the good results are due to antisepsis, and the complications to the accidental entrance of germs." Carbolized dressings were extolled for a long time, but then it was discovered that the carbolic acid evaporated and left the dressings non-antiseptic. Bichloride of mercury was used, but it has been shown to be untrustworthy, being converted into calomel. Hence arises confusion as to the use of antisepsis in all its minutiæ, but the great lesson of cleanliness still stands prominently to the front.

Lawson Tait, rejecting Listerism, but holding to carbolic ablutions and strictest cleanliness, shows a loss of only three per cent. in his last 100 cases of ovariotomy.

And now, gentlemen, believing that the society expects from each member his own individual views upon any subject, aside from text-books, etc., I beg leave to say that my own experience, however limited it may be, inclines me to the idea that in a country practice, where we have pure air, healthy surroundings, etc., there is no need for the spray. Absolute cleanliness or as nearly that as possible, together with the use of the antiseptics, locally, as a wash for the wounds, or rather as a cleansing agent—you may call it a germicide, if you please—is all that is needed.

In support of this view of mine, I desire to call the attention of the members to many of the operations performed by myself since 1872. In no case was the spray used, and no case has so far terminated fatally. All have progressed as favorably as could have been hoped for, except my first case, performed in 1872, in my earliest professional days. In my record book, I find that on March 17, 1872, I resected about six inches of the ulna for fibroma of its distal extremity. The after-treatment was entrusted entirely to another physician, and erysipelas followed, with a slow, tedious recovery, but with a perfectly useful arm and hand.

My second operation was performed about one week after the first—a case of lithotomy in a most unfavorable subject. A stone was removed measuring nearly six inches in circumference, and weighing more than three ounces. This case I watched myself closely for some time, and then entrusted it to a faithful nurse. The treatment consisted in keeping the incision clean by washing out with carbolized water. The result was recovery without an unfavorable symptom.

I find recorded in my case-book five amputations of the lower extremity—one, the lower third of the thigh—in which I did not perform the operation myself, but aided in it, and then took charge of the after-treatment. One case of Syme's amputation—two cases in which Syme's amputation was made, but the tibia and fibula were found so much diseased as to necessitate

amputation in both cases about two inches higher up the leg. One amputation just below the knee, in which case the patient, being a young man, no fever followed the operation, and if my memory serves me aright, was in town in less than three weeks, walking on a peg-leg of his own make.

I find two amputations of the arm—one just above the elbow, and the other performed June 25, 1884, for one of our best citizens, about two inches below the shoulder-joint.

I find, also, two cases of amputation of toes, and three or more of fingers.

One case of amputation of the breast occurs in my record book. The result in this case was primary union in nine-tenths of the wound, and a rapid cure of the remainder, but a return of the disease in a few months in the site of the wound, and the death of the patient from the original disease—cancer.

My record shows one case of removal of a cystic tumor from the mammary gland. Three operations—secondary—for lacerated perineum are recorded—all cured—two of them having been tested by giving birth to children within twelve months after the operation. I find also one case of laceration of the cervix, bilateral, in which one side was completely restored, and the other to about two-thirds of its extent, leaving only a slight notch on that side, reducing the depth of the uterus from $4\frac{1}{2}$ to $2\frac{3}{4}$ inches. I find one case of the excision of five inches of the radius, when the shaft had been shattered by a pistol ball. One case of traumatic aneurism of the superficial palmar arch, cured by ligation after pressure had failed. Two cases of hair-lip—about twelve circumcisions; as many or more operations for fistulæ; one fibroid polypus, large enough to fill the vaginal canal, and protrude through the vulva. The removal of this tumor was followed by profuse hemorrhage, which was controlled by large pledgets of cotton saturated with carbolized alum water and used as a tampon. When the cotton was removed, 36 hours afterward, there was neither odor nor hemorrhage after they were removed, but vaginal injections of carbolized water, as hot as could be borne, were used. One mucous polypus was removed, growing high up in the cervical canal. A number of cases of excision of tumors are recorded. One as large as an adult head, and one a fatty tumor weighing several pounds, removed from the shoulder of an old lady, aged 68 years. One case of extensive destruction of the skin and muscular tissue of the forearm by a burn from friction, in a man about 60 years old, illustrated to my mind the value of antiseptic cleanliness. In this case the forearm had been caught in the wheels of a rapidly revolving pulley, and subjected to the friction of a belt. After the separation of the sloughs, which was hastened by the application of charcoal poultices and the use of the dressing forceps and scissors, the temperature at no time went above $99\frac{1}{5}^{\circ}$, nor the pulse beyond 84. The case progressed slowly and steadily to recovery without a single untoward symptom. I might also mention cases of hemorrhoids operated upon in other ways than the one I now use, viz., carbolic acid injections. I might further call attention to an abscess of the liver, treated, after incision, with antiseptic washes, but I have occupied the time of the society long enough.

I desire, however, to revert to the second case of amputation of the arm referred to as having been performed June 25th last. Here the arm had been crushed by being caught by a band, and wound round a pulley of a steam thresher. The bones of the forearm were broken in two, and the humerus shattered just above the elbow. The muscular tissue had been reduced almost to a pulp, and the cutis destroyed to within $2\frac{1}{2}$ inches of the shoulder. The patient suffered much from the shock of the injury, and when operated on, 24 hours later, came near dying from shock on the table. By the free use of alcohol, ether, belladonna, and digitalis hypodermically, he rallied in the course of 36 hours, and from that time on till complete recovery, his pulse did not exceed 80, and the temperature did not rise above 99°. In two months the gentleman was engaged in hauling lumber to this place.

My management of these cases has been almost uniform. Cleanliness was impressed upon the attendants, nurses, and *patients* as of first importance. All discharges were removed twice a day—oftener if needed—and the circumjacent parts washed with a carbolic solution of the strength of ℥j. to ℥viij. of water. After thoroughly cleansing everything, avoiding any unnecessary application of the wash to the wound itself, the whole was then enveloped in a soft, clean, cotton cloth, saturated with carbolized cosmoline. In some cases I used Labarraque's solution, in others Listerine, and in others potassium permanganate; but my preference is decidedly for carbolic acid. In addition to the local treatment of wounds from operations, I nearly invariably keep my patients under the influence of a tonic. Usually I resort to tr. ferri perchlor. in full doses.

I would repeat that in all my surgical practice, I have never yet had a death. The most tedious

of all my cases was one of septicæmia, resulting from a case of pistol-shot wound of the thigh, in which the femoral vein had been divided and the hemorrhage controlled by a pledget of carbolized cotton pressed into the enlarged wound, and kept in place by sutures. Through some misunderstanding as to who was to take charge of the case, the cotton was not removed as soon as it ought to have been. At any rate, septicæmia resulted in this case, and for two months the result was uncertain. Under the free use of iron, quinine, arsenic, strychnia, and whisky, internally, and washing out the whole track of the ball with carbolized water, solutions of permanganate of potash, and other disinfectants and antiseptics, in spite of large abscesses and small ones nearly innumerable, the patient recovered, and is now a comparatively strong man, the wound having been inflicted nearly two years ago. Hoping, gentlemen, that you will accept this as a discharge of the task assigned me, I close.

ON HYSTERIA.

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The history of hysterics is very interesting, and withal instructive, as showing how the conception of it has changed through the centuries. Time was when a person attacked with it was thought to be possessed with a devil, perhaps more than one. To-day, though demoniacal influence is no more thought of, and it has been relegated into the vague realm of "neuroses," it is in reality as far from being understood as in the olden time, when it was ascribed to "the facing of the 7,425,926 devils of hell." (Richet.) It will not do, relying on the etymological significance of the word, to ascribe the phenomena so well known as "hysterical," to a diseased condition of the womb, and to separate it into the classes of Cullen: H. chlorotica, H. leucorrhœa, H. menorrhagia, H. libidinosa. Granting that it most often occurs in the female sex, no modern authority teaches either that it is always due to some uterine affection, or that it invariably is found in persons to whom, *sui generis*, such an organ belongs. Russell Reynolds says: "Hysteria is not necessarily associated with disease or derangement of the generative organs of either sex; such association may and does commonly exist, but the true nature of the malady may be overlooked if regard be paid exclusively to that particular condition." Skey, indeed, goes so far as to say that it is to be doubted whether there exists ever such relation between the symptoms and the uterus as to justify the name at all. Bartholow says: "That derangement of the female sexual organs, especially of the uterus and ovaries, is the essential cause of hysteria; is an opinion no longer entertained in any quarter." But the term has the sanction of long-continued usage, and therefore, though very misleading, it will probably be employed for many years, at least until we know more about it than at present.

Every one knows what is meant by "being hysterical," as this term is commonly used. Even to the lay mind, the phrase carries the picture of a chlorotic girl at or about the age of puberty, whose favorite diet is chalk and slate pencils, whose mental characteristics are not markedly brilliant, and who frequently has a "fit," during which she executes a variety of fantastic movements, tears at her throat, frightens her relatives by insisting on her immediate demise, and finally ends up by passing a large quantity of limpid urine, and in a few days is all right. With some modifications, this idea of hysteria is the one I have found generally prevalent in the minds of practitioners of medicine even. Now, while in very many cases this is no doubt correct, while it is true in the majority of instances, the classic description of an hysterical patient and the convulsion, handed down through a long line of text-books, is a good one, still there are many cases which do not accord with it; nay, which never have a convulsion, and yet which admit of no other explanation, and which can be called by no other name than hysterical. What then do I mean by hysteria? I mean a condition of the central nervous system, especially of that part of the cerebrum which has to do with introspection, the pathology of which is not known but is usually anæmia, which in different persons produces different disorders, motor, sensory, and psychic, said disorders commonly partaking of the nature of the diseases to which any special part is liable to be affected. In fine, I should call hysteric any symptom arising either in the course of another disease, or *per se*, which was unaccompanied by the concomitant circumstances usually attending such symptoms, which closest questioning, objectively and subjectively, failed to account for, and which, after an ordinary length of time, persisted, unchanged by medication, yet not affecting either the general health or other parts by contiguous or reflex influence. I am aware that the term "ordinary length of time" is objectionable, as "when the attention is strongly fixed on an organ of the

body, functional disturbances of it ensue, and finally structural changes may be induced." (Bartholow.) But to take an individual instance, when a patient vomits blood day after day without becoming anæmic or otherwise showing signs of disordered health, I cannot, after "an ordinary length of time," consider the symptom as other than hysteric, though I can readily perceive how this continuing for months may at last induce "structural changes." I know very well that in thus writing of and defining hysteria, I am encroaching on the ground occupied by neurasthenia, nervous exhaustion, or other complaints of like nature, which are just now in the heyday of life and vigor, but if we can speak of an hysterical joint and hysterical breast, I do not see why with equal propriety we may not apply the term to the multitudinous symptoms which many patients causelessly complain of, even though there may never have been an attack of vapores. If, therefore, I confound these several conditions, or seem to, I do it not unkowingly.

To the practical man it is of decidedly more importance to know the means by which true disease and no disease may be separated, and how the disturbed intellection may be so treated as to preclude the occurrence of these "nervous spells," or general "nervous" condition, than any discussion, either as to etymological derivations or strict definitions, desirable as these latter may be. I cannot hope to succeed where so many have failed, for by whomsoever an attempt at a complete diagnosis is made, come the words of Sydenham: "Hysteria resembles most of the distempers wherewith mankind are afflicted;" or stronger, the opinion of Skey, "That any part of the body can be the seat of such local derangement, either of the nerves of sensation or of motion, as shall accurately represent real disease of that part, when no disease, properly so-called, really exists." And, as if not making matters complicated enough, patients with real disease may have hysteric symptoms developing in its course, and then, as Dr. Conolly says, "they impart (to the real disease) a peculiar hysteric modification." Hysteria will simulate every disease in the nosology, from tabes to epilepsy and from phthisis to urticaria. Take, for example, the following instructive case reported by Dr. Walker in the *Archives of Medicine*, and copied in *Medical Gazette*, 1883. His patient was a pregnant woman in the eighth month when labor set in. On the third day she began to complain of headache, and suddenly became blind. She was in this condition when the Doctor saw her. He says, "She had passed only a few ounces of urine in the preceding twenty-four hours. Here then was a patient in the first stage of labor taken suddenly with pain in the head, and following it complete loss of vision." Certainly, as he remarks, "these symptoms would suggest impending puerperal convulsions." The doctor, however, had seen this patient before, and there was a chance to throw out the diagnosis of true puerperal convulsions by watching patiently and carefully. But hysterical symptoms are not always displayed as outbreaks of the nervous system, in which cases we are only too readily, for a time, deceived. But appreciable things, abnormal conditions realized by our senses, and abnormalities detected by our so-called "instruments of precision," do occur as symptoms of hysteria, and have no more significance, as I believe, than the globus hystericus. For example, hæmatemesis. This quite frequently occurs. All readers of Watson's Practice will recall his description of a girl who "vomited day after day potfuls of dark blood." I remember the case of a young lady, a blonde, aged about 17, just the complexion and build to suffer from gastric ulcer, whom I treated for a week or so for that affection. Finally, I gave up in disgust, when I found her developing undoubted hysterical symptoms, such as formication, numbness, and a strong inclination to lie. This girl vomits blood to-day, I was about to say whenever she chooses; but she looks well, is not anæmic, attends parties, etc. She has had since the first attack of hæmatemesis, hemichorea, paralysis of the muscles of phonation and of one arm; they all appeared suddenly, and disappeared as suddenly as they came. I don't believe that girl had an ulcer of the stomach. I believe the whole thing was hysterical in its origin, though I have no quarrel with any one who wishes to call it anything else. I have watched her now nearly two years, and my opinion is as above. Phthisis even may be feigned. Says Dr. Faber, *Medical Record*, reprinted from *Centralblatt für Gynacologie*, October 27, 1883: "There is in young women often a condition simulating phthisis. There is cough, with expectoration, and even spitting of blood. Physical examination reveals dullness at the apex (usually on the right side), feeble respiration, and occasional rales. * * * Sometimes, however, there is elevated temperature, but it is only transitory, and regular evening exacerbations are never observed." Peritonitis and colic are also simulated. Says Dr. Watson: "You will have a patient complaining of pain over the abdomen, aggravated by the slightest pressure, hot skin, quick pulse, and furred tongue," and

for these symptoms he says there may not be the slightest cause, so far as inflammation is concerned. Of colic Dr. Connolly (*Encyclopædia of Practical Medicine*) remarks that "the worst cases of colic I have ever seen have occurred in cases of hysteria."

I once saw a young married woman who presented all the symptoms of opium poisoning, though she had taken none of that drug. She was only in a stupor following an attack of hysterical convulsions. She lay in this state for 28 hours taking nothing in the way of nourishment, respirations from eight to twelve per minute, pupils contracted and muscles completely relaxed. After this state passed off she became totally deaf, and when she talked she drawled the words so that there were long pauses between them. Paralysis, aphonia, dysphagia, are also among the conditions which are noted as occurring in patients who really are having hysteria. But it is in the joints and among the vertebræ that hysteria loves to dwell. For some reason or another, the knee and hip joint and the spine are "spots of election" for hysteria to show itself. Sir Benjamin Brodie says: "I do not hesitate to declare that among the higher classes of society at least four-fifths of the female patients who are commonly supposed to labor under diseases of the joints labor under hysteria and nothing else." Skey, who quotes him as above, adds that he "would venture to enlarge this statement as regards the upper classes." Further on he says: "In reference to spinal affections I unhesitatingly declare that real disease is not found in a greater proportion than one in twenty, and even that is a liberal allotment." "I quote here as instructive the record of a case reported by Dr. Gibney in his article on *Neuroses of the Hip*, *Med. Gazette*, December 22, 1883. A girl aged 19 came to me on crutches, giving a history of good health up to January, 1880, when she had a fall followed by great pain in her knee. This shifted to the hip two weeks later, and she walked lame, suffering much from fatigue. For the past six weeks she has not been able to walk except with crutches. She has been very restless nights, and has lost flesh." His description of her is: "She stands resting all of her weight on the right limb, the left foot not even touching the floor; the left limb is advanced and rotated outwards, while the pelvis is tilted to this side. No infiltration about the joints, thighs equal in size, the pain is referred to the left loin, the spine, and the anterior surface of the knee. Absence of joint tenderness, but muscular tenderness with pain on pressure along sciatic nerve. The thigh can be almost flexed without pain or resistance. Indeed, all the movements are normal, save extension, which aggravates the pain. There is formication about the sole and ankle, with a moderate degree of dorso-lumbar tenderness." The doctor threw out joint disease, though it must be confessed it looked like it. He applied a fly blister to her spine several days, and on the tenth day she got up and walked across the floor, and by the first of August all symptoms of disease had disappeared.

Dr. Geo. Harlan, in a paper published in the *Medical News*, November 29, 1884, relates a case of hysterical monocular blindness, with violent blepharospasm and mydriasis, all relieved by mental impression. This case had followed a fall which had been diagnosed as a dislocation of the elbow, leaving her with the joint stiffened and her arm flexed at the elbow. Drs. Harlan and Cohen having already experimented on her with the Charcot magnet, and with one of their own device, made of wood and only tipped with metal, with the effect of curing the blepharospasm, now tried it on the biceps muscle, which is described as being in "extreme spasm," the "tendons standing out like whip-cords." "The spasm relaxed at once."

Hysterical deafness, hysterical blindness, hysterical anæsthesia, and hysterical hyperæsthesia, have all been noted. Disorders motor, disorders sensory, disorders vegetative, are all simulated by this Proteus. If then hysteria in its manifold manifestations is likely to take on the semblance of most diseases, the question comes to the mind of the physician, how shall I diagnose between it and true disease? Speaking now for myself, I state frankly that I have often made mistakes. I doubt if that physician lives who has not been fooled and diagnosed some organic lesion, some true disease, where none *per se* existed. To make a diagnosis of hysteria is not always easy, nay, is often difficult. Ordinarily the hysterical spasm, the attack of vapors, is diagnosed in a few minutes without difficulty. There is something about it that stamps it distinctively, though its cause may be beyond detection. We may say, generally speaking, that in hysterical convulsions there is always an effort on the part of the patient to attract attention and create a sympathetic feeling in the minds of the bystanders, and she is usually much more quiet if let severely alone. Then, too, absence of any history that would give rise to an attack of such seeming severity, aids us. This is what I usually rely on—this and careful watching and waiting;

a few months often throws a good deal of light on this class of patients. But to diagnose those cases of hysterical joint and breast, of hæmatemesis and vomiting, of anæsthesia and blindness, not to mention a hundred other conditions, "ay, there's the rub."

Again, the history of the case must be the main reliance. But we shall be fooled, fooled by the thermometer, fooled by electricity, fooled by the stethoscope; time usually solves the difficulty. If these affections complained of so pitiably, and of such seeming severity—and I have never known a hysterical patient to complain of any symptom or set of symptoms which, on the surface, did not seem dangerous and urgent—go on for days without affecting any other organ or the general health, we are, I think, justified in calling them purely neurotic, and dismissing all thoughts of danger from our minds. But, alas! thus dismissing the thoughts of danger does not get rid of the patient, who, with a pertinacity worthy a better cause, will swallow incredible quantities of drugs, and submit to any amount of blistering and firing to get relief from a complaint which exists only in a disordered imagination. To the mind of the physician, when treating either the convulsion of hysteria, or this other class of cases, there has often come, I doubt not, that sentiment which Shakespeare applies to wine: "If thou hast no other name to be known by, let us call thee devil."

Weir Mitchell has told us well and truly how to deal with some of these patients, and his "rest treatment" and forced feeding are well worth a trial. Where there are local manifestations, fly blisters, washes of lead water, and opium and poppy poultices, made either of the leaves, or what I have found very efficacious, made of the sediment or leavings after the manufacture of laudanum, do good, especially in that condition known as "hysterical breast." The Charcot magnet—probably the Harlan-Cohen magnet is just as good—will frequently yield good results. Little medication is needed; the less the better. Hyposulphites of lime and soda, and the chloride of gold and soda, are good general and special tonics; as a cathartic nothing equals a pill of aloin, belladonna, and strychnia. I do not like to use the sedatives in such cases, but if forced to, prefer a mixture of valerian on account of its bad smell, assafœtida for the same reason, bromide of potassium or soda, made up with the elixir of sumbul. Rarely are we forced to use opium. I have seen though the best effects from a pill of hyoscyamus, and camphor, combined with a minute dose of morphia.

As to the treatment of hysterical spasms, I am favorable to the use of emetics. I think it is Dr. Goodell who says that "when a patient vomits she can't do anything else." An emetic of sulphate of zinc or ipecac is efficacious in quite a number of cases. I am more favorably inclined toward this way of treating the hysterical convulsion since reading Dr. Turner's report of four cases, MEDICAL AND SURGICAL REPORTER, January 17, 1885, from the *Texas Courier-Record of Medicine.* I believe this treatment, followed by some sedative, to be *the* treatment for a large majority of these cases. It goes without saying that all disturbing influences should be removed, and that weeping friends and anxious relations should be rigorously excluded from the room.

I do not know that I have written anything new in this article. My purpose has been to draw the attention of practitioners to a class of cases—hundreds of which exist—which are often overlooked and in which mistakes in diagnosis are often made.

HOSPITAL REPORTS.

A CLINICAL LECTURE DELIVERED AT THE PHILADELPHIA HOSPITAL.

BY HORATIO C. WOOD, M. D., LL. D.,

Professor of Diseases of the Nervous System in the University of Pennsylvania.

Reported by WILLIAM H. MORRISON, M. D.

Senile Gangrene—Senile Dementia—The Treatment of Old Age—Polio-Myelitis—Probable Apoplexy.

GENTLEMEN: I wish in the first place to show you two cases, neither of which are open to therapeutic measures, but which will serve as the basis of a few remarks in regard to the treatment of a very frequent and important condition, namely, old age.

We have here two types of the results which may be considered as belonging to old age. This man is 77 years of age, and was able to work until sixteen days ago, when on account of some peculiar sensation in the left foot, he applied a mustard poultice to it and went to sleep, waking up at the end of eight hours to find the foot in a condition similar to that which it now presents. At no time has there been any pain connected with this. This affection does not usually come on in this painless manner. More commonly it begins with a horrible, stinging pain, which, as a rule, is felt in the neighborhood of the large toe. If the part is examined at once, it will be found to be red or of a peculiar dusky or livid hue, and in the course of a few hours or in a day or two, it becomes black, and there is developed the condition ordinarily spoken of as dry gangrene. Here, as you see, we have an illustration of dry gangrene, although this is slightly more moist than in the typical condition.

The cause of the development of this affection

is always failure of circulation in the part. Examining the pulse in this case, I find it irregular and feeble, showing that there is cardiac failure. The arteries are hard, and have an irregular, beaded feeling. In other words, there is atheroma of the arteries. The condition of the foot has resulted from the failure of circulation, due partly to heart failure, but chiefly to atheroma of the vessels.

Examining the part closely, it will be observed that there is a tendency to the formation of a line of demarcation, but it will also be seen that the black discoloration is spreading above this line.

The only thing to be done in a case like this is to give opium in small doses frequently repeated, so as to make the patient comfortable and to wait for nature to effect the final result. There is no use in attempting any surgical procedure. If the leg were amputated, sphacelus might appear above the seat of operation, if, as would be more probable, the man did not die from the shock. Again, secondary hemorrhage is apt to occur, and the primary hemorrhage may be severe and even uncontrollable. The vessels are hard and rigid, and break when the attempt to ligate them is made.

Senile Dementia.

In this man we have what may be considered senile dementia. It is easy to see from his answers to my questions that there is a total failure of memory, and that the history which he gives is a mixture of old fleeting reminiscences of his past life with his present impressions. Along with the mental failure which usually begins with weakness of memory, there is failure of muscular power, so that there is inability to walk.

So far as treatment is concerned, there is little or nothing to be done. The only remedy required is morphia in doses sufficient to make him comfortable. The diet should be carefully regulated, and then we wait the natural result.

I wish to say here, taking these cases as an excuse, a few words in regard to the management of old age. Old people will often be among your most profitable patients, and you will be frequently called upon to give advice in regard to the prolongation of life. In carrying this out, there are three ideas to be considered. I am now supposing that you are treating an old person with abundant means. The first thing is protection from all untoward influences. A large proportion of those who are said to die from old age, really die from the effects of exposure, and it must be remembered that the term exposure is relative. What in a young man may be nothing, may to an old man be a serious matter. One of the most perfect protections from cold is a buckskin jacket. Every person who is 75 years old, and whose physical powers are beginning to fail, should be put in a buckskin jacket, extending from the shoulders to the hips. There is no flannel, silk, or anything else, which will compare with buckskin in preventing chilling of the body. Chilling of the surface in an old person means a rush of blood to internal organs, where from weakness of the vaso-motor system and the condition of the vessels, contraction cannot take place, and the congestion is even apt to be followed by pneumonia, or other inflammation must result.

These patients must be guarded especially against exposure to wind. Damp is feared by many and credited with causing many affections, but where damp has slain its thousands among the aged high winds have slain their tens of thousands. This caution applies not only to old age, but to all cases in which there is a tendency to cardiac failure. Some time ago a noted clergyman of this city came out of church and started to walk to his residence in the face of a northwest wind. He had gone only a square, when he stopped, seized a railing, gasped a few times, and was dead. If he had not faced that wind in his exhausted condition after prolonged public speaking, he probably would have been living at the present time. High winds chill the surface, oppress respiration, and are exceedingly disastrous to the life of any person whose circulation is without power.

I need not say anything in regard to preserving the nervous system from all shocks. Fortunately, as the intellectual powers become blunted, so do the emotional energies, and the old man is not so susceptible to emotional disturbances as is the man whose nervous system is unaffected with age. All accidents are of course to be carefully guarded against, and all excessive bodily or mental exercise. Remember, excessive is a relative term, and for the weak excessive may be very little. Rest is of great importance; indeed, old people should spend many hours in bed.

The next point is in reference to diet. The food should be light but nutritious. Stimulating food should be withdrawn. Meat should be used but sparingly. What we start with, to that we finally come in this life. Man, who begins on milk, should in the last years of his life make milk the chief article of his diet.

Finally, in regard to medicines. There are two drugs which are of the greatest importance to old persons. These are alcohol and opium. If your patient, approaching his eightieth year, can be made an opium eater, you will in the majority of cases protract his life many months or years. In these cases the opium is to be used carefully, and in such a way that the patient can not rapidly increase the dose of it. A number of years ago I was called to see an old man. He was thought to be dying at that time, but he is still alive at 84. For the past ten years he has taken an opium suppository every night, but beginning with one grain, he has now only reached two and a half or three grains. When he is restless, or there is a tendency to diarrhœa (for he has suffered with enteritis for a number of years), he takes two or three suppositories. Unless the patient has more than the ordinary will power, it is essential that the opium be administered by some one else.

Again, the use of alcohol in old age is of great importance. Every old person should take alcohol in some form, three or four times a day. It should be given at meal time. I think that it makes little difference whether dilute brandy or whisky, or some of the wines are selected. The wines are more palatable to some. It is also important to study the digestion of the patient, for in some it is found that the diluted liquors answer best, while in others the wines are most serviceable.

This is but a brief sketch of the measures to be employed to prolong life, and I may add that it is essential that in the old any attack of disease must be stopped in its incipiency, and for this purpose there is nothing more efficient than opium and putting the patient to bed.

Chronic Polio-Myelitis.

A glance at the exposed shoulders of this man, at once shows that there is distinct wasting of the left shoulder. There is a peculiar flatness at the point of the shoulder, which is characteristic of wasting. The left arm is much smaller than the right, but the forearm is not affected. When the attempt to raise the arm is made, there are peculiar fibrillar contractions of the deltoid and upper-arm muscles, with tremor. Wherever there is wasting of the muscles with the history that this has developed slowly with loss of power and fibrillarly contractions, you have almost always a case of chronic polio-myelitis, or progressive muscular atrophy. In true chronic myelitis, there is no pain. In a case of alleged paralysis, the first question to be decided is whether the paralysis is due to loss of power or to the pain which is caused by movement. The man moves his arm without feeling pain, and extensive passive movement can be made without causing pain. The fibrillar contractions are quite marked during passive movement. Sometimes these quiverings can be brought out by tapping the muscle, but such is not the case in this instance. Do not be misled, however, and as soon as you have this fibrillar contraction with wasting of the muscle, conclude that you have a case of progressive muscular atrophy; for in wasting diseases like phthisis, tapping the muscles will frequently excite fibrillar contractions. The significant fact in cases of progressive muscular atrophy is the localized nature of the change. Where there is this localized wasting of the muscle, which cannot be attributed to rheumatic inflammation, neuritis, traumatism or overwork, the chances are that it is due to chronic polio-myelitis. The probabilities are therefore that this man is suffering from chronic polio-myelitis, or chronic muscular atrophy.

Infantile Paralysis.

In connection with the previous case, I wish to show you this man, twenty-eight years of age, who has been unable to walk since he was one year old. His legs are cold, and as you see, blue and much wasted. Without spending much time on the case, I will say that we have here the results of an acute attack of polio-myelitis, that is, what is ordinarily known as the essential paralysis of children, or infantile paralysis.

Polio-myelitis is a disorder or the large cells of the anterior cornua or gray matter. It appears in two forms; first, the acute variety, very common in children, but rare in adult life, although occasionally occurring, and known as infantile paralysis or essential palsy of childhood. In the second place, there is the slow chronic form of the disease, rare in childhood, but occurring in adult life, and producing the disorder which we have just seen, viz., progressive muscular atrophy.

The present case is also interesting as showing that not only is the nutrition of the muscular tissue dominated by these cells in the spinal cord, but that the nutrition of the bony system is also dominated by them. It can be readily seen that this man's legs are shorter than they should be. Where only one leg is affected, there is often a difference of one or two inches in the length of the limbs.

There is, of course, nothing to be done in the way of treatment. In the early stages of acute essential palsy, something can sometimes be done to aid in arresting the disorder; but here the storm has passed, and the spinal cord is lacking in certain elements which can not be replaced.

Probable Apoplexy.

This man, forty-six years of age, comes to us with the history, that he has all his life worked hard as a laborer; that he has used alcohol in excess; that fifteen years ago he had a chancre, followed by well-marked secondaries; and that last March (eight months ago), he was attacked with what is said to have been rheumatism, and came to the hospital. He was relieved and discharged. He remained in his usual health, with the exception of constant headaches, until ten days ago, when the present ailment developed.

Early on Monday morning, while working at the fire in a stove, he felt as though he had been struck on the top of the head. He did not fall, but noticed that he could not talk distinctly. He then went to bed; and the following day, on attempting to rise, found that he was paralyzed. The headache of which he speaks has been pretty constant; sometimes it would come on suddenly, continue for a few minutes, and suddenly go away. He also had noises in the ears.

The first point in the diagnosis is to determine, if possible, whether this man has had an apoplectic attack, or whether he has palsy resulting from cerebral syphilis. At times, the diagnosis between these affections is very difficult, and occasionally it is impossible at first to decide whether there is a clot in the brain or whether the paralysis is the result of congestion and softening around a syphilitically inflamed portion of the brain.

Remember that syphilis is one of the great causes of atheroma, and also that the use of alcohol is another important cause of the same condition; therefore, where there is such a history as has been elicited in the present case, the existence of atheroma is to be at once suspected, and examination of this man's arteries confirms this suspicion. Again, when I place my ear over the præcordia, I find that the second sound has a peculiar clanging character, which is sometimes said to be associated with hypertrophy of the heart, but which I believe is almost pathognomonic of atheroma of the aorta. When you get an aorta that is atheromatous, excessively rigid, and lacking in elasticity, but in which there is no true aneurismal dilatation, you find this peculiar sound, which seems to me to be due, at least in part, to the wall of the aorta reinforcing the clanging sound of the valve, just as the old-fashioned sounding-board in the Quaker meeting-house reinforced the voice of the speaker.

There are, therefore, in this man, the conditions which predispose to apoplexy; but we have these same conditions present in almost all cases of syphilis. For practical purposes, however, I think that we may consider the diagnosis of apo-

plexy reasonably certain when we find that the paralysis develops in the course of a few minutes and is complete; while on the other hand, in a person suffering with syphilis, in whom the paralysis develops in the course of a few hours, and is not complete, and has been preceded by headache or other symptom of cerebral disturbance, there are grounds for believing that no clot is present in the brain, and for hoping that the patient will recover from the paralysis under the influence of anti-syphilitic remedies.

Applying these rules to the present case, it is found that the paralysis was preceded by headache, and according to his statement, the paralysis did not develop immediately. If we could be certain that this statement was correct, there would be grounds for considering that the palsy was the result of syphilis. It must be borne in mind, however, that we are dealing with a person who has not been in the habit of making close observations, and no person after an attack of this kind is in a position to make correct observations. We cannot determine positively whether the paralysis was complete or not at the time he first noticed it, but at the present time it is complete; and this fact, taken in connection with the distinct description of the feeling of a blow on the head, leads me to believe that the history in regard to the rate of the development of the paralysis is incorrect, and that the man was paralyzed shortly after being put to bed, although it was not recognized at that time.

I have seen a number of cases of apoplexy in which this feeling of a blow on the head was very marked. It is not always present, but is often the result of the rupture of a blood-vessel of the brain, with the sudden effusion of blood. Some years ago, I saw an old gentleman who had received a great shock to the nervous system while at dinner at a friend's house. He left the table and went to his own house. An hour or two later, he suddenly went to the front window, threw it open, and yelled "murder" at the top of his voice. Passers-by rushed to the door and forced their way in, and going up stairs, found the old gentlman lying on the floor, partially conscious. He was just sufficiently conscious to assert that somebody had struck him a violent blow on the right side of the head. He rapidly grew worse, and died in the course of a few hours from well-developed apoplexy. At the autopsy, a clot of blood was found just at the spot where he said the blow had been struck. If that man had been situated somewhat differently, or if there had been a quarrel, there would have been strong legal evidence that the man had been hit. The man had never been hit, as it was perfectly clear that he was in the room by himself and suddenly fell to the floor.

After a stroke of apoplexy, there is also great confusion of mind. Some years ago I made a curious test of this. An elderly gentleman was seized with a stroke of apoplexy, which passed over, and he came out apparently entirely rational. I determined to test his mental condition. He could see only with the left eye, having a glass eye on the right side. I said to him: "Has this thing affected your sight?" He replied that he thought not. I then told him to cover the left eye. "My God," he exclaimed, "I am going blind." There was that mental confusion which made him forget for the moment that one eye was really blind. This mental confusion is an important matter in medico-legal questions, especially in regard to wills.

I think that in the present case the mental confusion was such that although the paralysis was present at first, the man did not recognize its existence, and that we have a case of apoplexy to deal with.

Medical Societies.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

(*Concluded from page* 432.)

At first no thought was entertained that did not suppose the tumor was in some way associated with the liver. Abscess, lardaceous disease, and cancer, however, were excluded by the absence of the other essential symptoms, and it was finally thought that we had most likely to do with a hydatid cyst. This was based upon exclusion of an obscure sense of fluctuation at the most prominent part of the swelling to the right of the umbilicus. Accordingly, on December 12, I introduced an exploratory needle to the depth of 4 inches at this prominent spot. A few drops of bloody fluid only were drawn, which showed, upon microscopic examination to contain no distinctive elements. Forced by the results of this operation to abandon the liver as the seat of disease, the kidney was then selected as its probable seat, although repeated examinations of the urine had shown that while it was somewhat diminished in quantity, it was otherwise normal. It was ascertained, however, twice, that it did not contain iodine after the administration of 5 gr. of this substance. Soon after the 1st of January, 1885, his stomach ceased to retain food, after which he declined more rapidly, and died January 16. As the disease progressed, the tumor presented through the abdomen walls, and also to palpitation, a more uneven outline, which could not, however, be described as nodulous. At the autopsy there was noted on inspection œdema of the right leg, and a tumor occupying the space between the ribs and the ilium on the right side, extending three inches beyond the median line. It was bumpy or uneven. The hand could be pushed up a short distance between the ribs and the surface of the tumor. On section, the visceral and parietal peritoneum appeared normal, and the omentum partially covered the abdominal contents, but was adherent only in the right iliac fossa. The colon was displaced, and commencing at its head in nearly the normal situation in the right iliac region, extended upwards and to the left, along the border,

The right kidney was found closely applied to the front of the tumor, and so closely that it was at first overlooked, and the tumor thought to be one of that kidney. It was compressed, flattened, thinner than an average hand, and smaller in circumference than the normal organ. The minute examination of the right kidney revealed a very interesting condition. The tubules bore evidence

of the compression to which the organ had been subjected. The cells were everywhere compressed, and the tubules narrowed. There was a slight hyperphasia of intertubular tissue, especially about the malpighian bodies. The ureters and bladder were normal. The pericardium and heart were normal; the left pleural sac contained a small quantity of bloody serum, and there were a few trifling adhesions.

The left lung contained along the outer anterior edge of the upper lobe, three inches from its base, a moderately firm nodule one-half inch in diameter, pinkish-grey on section, and projecting above the adjacent cut surface of the lung. Two similar reddish-grey nodules were found on the lateral aspect of the lower lobe of the lung, about four inches from its base. They were about an inch apart, about $\frac{3}{4}$ of an inch in diameter, and projecting as much below the lung almost as sessile tumors. There was another small tumor on the posterior of the base of the lobe. There was more than the usual adhesion between the two lobes of the lung. The lower lobe of the right lung was much adherent to the diaphragmatic as well as the thoracic pleura. There was a warty excrescence about $\frac{3}{4}$ of an inch in diameter, attached by a small pedicle to the upper lobe, and a still smaller one at its anterior edge. The nodules in both lungs were encapsuled. The tumor itself was lobulated, and occupied the entire right side between the edge of the ribs and the pelvic bones, and extended even to the left of the median line in the neighborhood of the umbilicus. It presented the same obscure sense of fluctuation, and upon section of the lobes of which it was composed, each one of which appeared to correspond with an original lymphatic gland protruded in its central position, and presented a uniform pinkish-grey surface, of moderately soft but by no means defluent consistence. The microscopic examination revealed throughout the structure of a sarcoma of the tumor mass, to the region of the spleen, where it turned inwards and made two or three twists along the left side of the abdomen. The right side of the liver was slightly enlarged, but the organ was otherwise normal. There were no adhesions whatever, and its surface was smooth. It was unusually firm on section, and the lobules seemed to have been compressed.

The spleen was slightly harder than usual, but otherwise normal. The pancreas and stomach were both displaced backwards and to the left. The former was normal, as was also the latter, except that there were a few punctiferous extravasations in its cardiac end.

The left kidney was found buried beneath the left portion of the tumor, and appeared one-third larger than normal. The capsule stripped off easily, leaving a smooth, dark-red surface. On section the cortex seemed slightly broader than in in health, and was darker in hue. Thin sections, studied microscopically, showed a normal histiology. The organ was simply hypertrophied.

Dr. J. H. Musser asked whether the tumor moved synchronously with respiratory movement? for if connected with the liver such would be the case. He would also like to know whether hydatid fremitus, so-called, were present, and by what sign was the diagnosis of hydatid tumors made?

Dr. Musser also asked the position of the left lobe of the liver, for if displaced it would have indicated possible dislocation of that organ, a condition well known to ensue in tumors of the right kidney on account of the direction of their growth. He thought a tumor of the right kidney could have been eliminated by the direction of the growth of the present tumor, viz., downwards and outwards.

Dr. Tyson said that with regard to its mobility it was certainly a fixed tumor. There were no signs of hydatid fremitus, this diagnosis having been arrived at by exclusion, and the obscure sense of fluctuation which could be detected.

Dr. Shakespeare said there was also a small lobulated tumor on the left side of the vertebral column, entirely covered and concealed from view by the fibres of the head and belly of the left psoas muscle. He suggested that the origin of the large right-sided tumor may possibly be explained in the same way; for not only the kidney and ureter, but also the large vessels were pushed forward and to the left border of the tumor mass, and no remains of the head or belly of the right psoas muscle could be found. The location of the retro-peritoneal glands of the lumbar region is mainly in front of and around the main vessels. They are far in front of the psoas muscle, and can with difficulty under all, the circumstances of this case, be regarded as the origin of this large tumor.

Dr. Shakespeare would ask Dr. Tyson whether the pain complained of was referred to the anterior crural or the sciatic nerves.

Dr. Tyson replied that he could not be certain whether the pain in the left leg was along the distribution of the anterior crural, but thought that it was. Certainly in the right leg the pain pursued the course of the branches of distribution of the sciatic nerve.

Larynx, Trachæ, Lungs, and Heart, from a Case of Anginose Diphtheria.

By W. A. Edwards, M. D.

This case occurred in the practice of Dr. William M. Powell, of this city, at whose request I saw the little patient, and for whom I made the post-mortem examination.

Lizzie P——, aged two years, of a strumous diathesis, was first seen by Dr. Powell on February 2, 1885, when she appeared to be suffering from catarrhal fever, but at his next visit, two days later, a diphtheritic membrane was easily recognizable over the uvula, tonsils, and half arches.

The child grew worse, the membrane increasing, the cervical and post-cervical glands enlarging, pulse running high, hyperpyrexia, and the case rapidly assuming a malignant aspect.

On last Sunday (the 8th), after consultation, the plan of treatment was slightly changed, apparently to the child's benefit, as she improved until about eight in the evening of the 11th, when her respiration was noticed to become fish-like, extremities cold, pulse high and thready, increasing apnœa, and sudden death at 9:30 p. m. Post mortem fourteen hours after death.

Female child, fairly well nourished, in the right eye is to be seen a corneal opacity, probably the cicatrix following phylectenular keratitis.

The larynx, unfortunately, was somewhat mutilated in removal, as an incision in the neck was not permitted. Some œdema may be noted, and in the recent state areas of hyperæmia were observed, probably the seat of membrane.

The trachæ presents these areas much more plainly.

The glands at the root of the lungs and along the trachæ are much enlarged and indurated, one is lodged just at the bifurcation of the trachæ and probably had some causal relation, through pressure, to the emphysematus condition of the lungs.

Thorax: lungs, the pulmonary and costal pleura, are adherent, as is also the diaphragmatic, the lobes of the lungs are bound together by slight adhesions. In numerous spots over the lung tissue are to be seen small areas of emphysematous dilatation.

Cross sections of the bronchiols show exuding muco-purulent matter well aërated. No effusion is to be seen in the pleural cavities.

The heart appears to have undergone some dilatation of its right cavities; the valves are normal, the left side is firmly contracted, with normal valves. Contrary to our expectations, no clots were seen either in the heart, plumonary artery, or aorta, with the exception of a very small one entangled in the cordal tendinæ of the right ventricle. No effusion within the pericardium.

Liver normal; spleen somewhat enlarged. Stomach contained a large quantity of undigested milk; over its surface are seen numerous centres of ecchymosis. Kidneys and brain not examined.

The cause of death in this case becomes an intesting inquiry. The child was practically well of the diphtheria, and was progressing nicely towards convalescence, when suddenly signs of apnœa appear, deepening into death. As was noted above, the right auricle and ventricle appear to have undergone severe dilatation; this, to my mind, was the cause of death in our patient's case, as *sudden and considerable dilatation of the cardiac cavities, more especially of the right heart*, may be remarked at the bedside, and in many febrile cases causes sudden death from heart failure.

Dr. Tyson said that the cause of death in diphtheria seemed best explained by the theory of Dr. Edwards, which is a very reasonable one, and that this dilatation of the heart cavities was the result of a rapid fatty degeneration of the heart muscle, a condition of frequent occurrence. Theoretically digitalis was considered useful in this form of heart failure, but if due to fatty degeneration it could of course produce no effect. Affections of the cardiac ganglia he did believe produced this heart dilatation.

Dr. Edwards said that Dr. Beverly Robinson had reported examinations in which he could find no fatty degeneration, and Dr. Edwards himself, in three cases of rapid dilatation of the right cavities occurring in typhoid fever, had failed to find evidences of fatty degeneration; these cases were published in the medical journals about one year ago.

—A Russian translation of Dr. Weir Mitchell's admirable brochure on "Fat and Blood," has just been published in St. Petersburgh.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Dr. C. W. Dulles read a paper entitled

Suggestions from Dispensary Experience, for the Surgery of General Practice,

saying: It has often seemed to me that the experience gained in the many dispensaries of our large cities is not made of as much service to the profession as it might be, and that it would not be amiss if those who have the advantages which these positions afford would occasionally try to put into accessible shape the lessons which they have there learned, and lay them before their brethren for adoption or correction. And, because I have had to learn by experience some things which it would have been better for my patients if I had found out in some other way, I have thought it might be worth while for me to invite your attention to certain notions in regard to the kind of surgery which occurs in general practice, which I have gathered during the past ten years, and which, if they are correct, may be helpful to others; if they are incorrect, I shall be glad to have criticised.

In order to arrange a somewhat desultory subject in as orderly a way as I can, I shall divide it as follows:

1. The examination and diagnosis of surgical lesions.
2. The cleansing of wounds.
3. The control of hemorrhage.
4. The dressing of wounds.
5. Bandaging.
6. Splints.
7. The sling.
8. Constitutional treatment.

1. THE EXAMINATION AND DIAGNOSIS OF SURGICAL LESIONS.

I trust I shall not be deemed officious in urging the importance of thoroughness and discernment in making up a diagnosis as to what is the nature of the lesion for which one is consulted by a sufferer. Every writer, and every lecturer, dwells, more or less, upon this point. But, in spite of all that is said and written, mistakes are constantly being made, which greater care would have prevented. I have seen fractures treated as contusions, and contusions as fractures, over and over again. I have seen a patient treated for a fracture at the lower end of the radius with a time-honored Bond's splint, who had nothing the matter near the wrist, but who had a severe and dangerous contusion of the elbow-joint. I have seen hydroceles treated for years as herniæ, and have been called to operate for strangulated inguinal hernia when there was only a hydrocele of the cord, innocent and easy to cure. I have seen a psoas abscess mistaken for a hernia, and over and over again sinuses of the face, due to disease of the root of a tooth, treated in vain as simple abscesses, the recognition of the cause and the removal of the offending tooth being followed by a prompt recovery. I do not care to cite many mistakes of my own, but I cannot forget my mortification once when caught napping by an ulcerated knee, the syphilitic nature of which was indicated and easily demonstrated when a more experienced surgeon asked to see the other leg. On the other hand, I have known lesions to be

characterized as syphilitic on what I thought to be an unwarrantable suspicion, and a cross-examination to show that what a patient called a chancre could not possibly have been the initial lesion of syphilis.

Now, such errors should not be passed over, or hushed up, when we are speaking among ourselves, or we shall miss the advantage of being taught the necessity for constant vigilance and thoroughness in examining our patients.

Of course, this is not the place to discuss the diagnosis of various lesions; but it may be worth while to call attention to the importance of making our examination include, not only the part believed by the patient to be injured, but also the surrounding parts—muscles, bones or joints, as the case may be—for some distance above and below. The opposite and corresponding parts should often be looked at, for purposes of detection or comparison. Nor should we hesitate to call to our aid the probe or the exploring needle, both of which are valuable and harmless instruments in judicious hands.

Two little points, in regard to the sinuses of the face, I would like to speak of. One is the well enough advocated examination of the teeth, by inspection and tapping, to detect a state of abscess in the alveolus; the other I do not remember to have seen recommended. This is, to test a suspected salivary fistula by bringing a drop of the discharge into contact with a drop of the tincture of chloride of iron on a white surface—a piece of white paper will do—when, if the discharge contain saliva, it will give the pink color which indicates the presence of the sulphocyanide of potassium, a normal ingredient of saliva.

And, before dismissing this subject, I think a word may be said as to the failure, when one is really at a loss, to get the opinion of some one who is more familiar with our subject than we are. However proper the motives may appear which lead to this, they cannot avert from the patient the consequences of error or delay in diagnosis or treatment; and I believe it would be greatly to the advantage of our patients and ourselves, if we accustomed them to the idea of having a consultation before a case becomes extreme.

2. THE CLEANSING OF WOUNDS.

My own experience has led me to the belief that this salutary proceeding is sometimes overdone. When we see a scalp-wound, or a laceration of the face, covered with a scab, even though it be not a very handsome one, good surgery does not, I think, require us to take it off, unless the appearance of the neighboring parts indicates that an inflammatory process is going on under it. Nor, when a crushed finger is enveloped in dry covering of blood and machinery grime, need we think our patient's safety depends upon a thorough removal of these. On the contrary, I should say his rapid recovery often depends upon our letting them alone. But scabs that cover pus may always be removed with advantage; and foul secretions, or accumulations, can only do harm, and must be cleaned out. So the cleansing of wounds is not only an æsthetic, but also a salutary, procedure. As to the method of cleansing, I am a convert to the views of Mr. Sampson Gamgee, who never uses a liquid for cleansing when it is not specially indicated. Careful mopping with dry cotton or lint will do far more than those who have not tried it would imagine. Rubbing is rarely called for, but just touching with the cotton or lint, and pressing it down with more or less firmness, as the circumstances require. But, when the case demands it, we must not hesitate to rub firmly, even a little roughly, or to pick off or cut off what sticks tight to the healthy tissues.

However, we should not eschew the use of water too tenaciously. It is often indispensable, and, combined with a little permanganate of potash—just enough to make a transparent, pink solution—it is a *sine qua non* in dispensary practice, as a disinfectant and deodorant. This combination, it seems to me, excels every other so-called antiseptic; and carbolic acid, I may say, I never use as an antiseptic at all.

In this connection, I wish to emphasize what I think is a very important matter in washing of wounds and sores, namely, that the same fluid should never be used twice; that is, it should not be dipped from a basin and allowed to flow from the wound or sore into the same vessel, and then dipped up and used again, and so on. The best way of washing a wound would be to let the water run upon it from a hose with a regulated force. But almost, if not quite, as good as this, is the plan of having one vessel to hold the wash and another to catch the drippings, and to apply the wash by letting it fall in a steady stream from a clean sponge or a mass of oakum. The size of this stream, and its force, can be easily regulated by the force with which the sponge or oakum is squeezed, and the height at which it is held. If the dripping mass be grasped in the hand and held with the thumb up, by well-regulated squeezing a single stream can be made to fall from the dependent portion in exactly the place and way we wish.

3. THE CONTROL OF HEMORRHAGE.

An important part of the preparation of a wound for dressing, is the control of hemorrhage—I do not mean the hemorrhage from large vessels, but that from small ones, such as are usually encountered in the surgery of general practitioners. Our colleague, Dr. Roberts, has, I think wisely, deprecated the routine use of styptics, and I quite agree with him that, for almost all small vessels, the pressure of a well-applied dressing will do all that is needed in the way of controlling hemorrhage. Such a dressing may be made of dry lint, bound on with moderate firmness—actual tightness is not called for—and often one will have, in a little while, an imitation of nature's favorite method of healing, by the formation of a scab, made up of dried blood and the tissue of the dressing. The essentials for controlling moderate hemorrhage are dry dressings and moderate compression. Pressure alone is sufficient to control the bleeding from scalp-wounds, which are sometimes spoken of as if they were troublesome to deal with. It is remarkable, at times, to hear men describe the pains they have been at to ligate an artery of the scalp, in view of the fact that this is never indispensable. A compress and a bandage will control any vessel in the scalp, and almost anywhere else; and, if

an unruly patient is likely to pull a bandage off, a pin, even a common one, may be thrust under the vessel and brought out again beyond it, so as to hold it as long as any one could wish. If still greater security be desired, it can be had by adding a "figure 8" to this pin.

And here I wish to add a word as to the need for stopping bleeding. I will go a little further than Dr. Roberts in regard to the innocence of hemorrhages which sometimes cause great uneasiness. Many of these hemorrhages are absolutely beneficial. Of course, one need not be foolhardy; but such hemorrhages as come from superficial wounds may be regarded with the greatest equanimity, and no one need get flustered in trying to stop them. In my own experience, I often encourage bleeding to a considerable extent, as in the case of incisions for felons and palmar abscesses, and the like, and have never felt that I lost anything by being deliberate.

Hemorrhage from small vessels can often be controlled by a firm pinch with the forceps, or the vessel may be drawn out and twisted round several times. This will often obviate the necessity for ligatures, in operations such as circumcision of infants or children. Sometimes the arteries in the fingers will bleed in a most troublesome way. If the bleeding cannot be stopped by pressure or torsion, it can be controlled by a pad of lint and a few circular turns of adhesive plaster. Persistent hemorrhage from an alveolus, in one with a hemorrhagic diathesis, I have controlled, when plugging gave only temporary relief, by injecting a fine stream of cool water against the bleeding point. Bleeding from the wound of the palmar arch can, I believe, almost always be controlled by a pad and bandage.

4. DRESSING OF WOUNDS.

Dry Dressing.—Nature's method of protecting wounds is by the process of scabbing; and when we reflect upon the successful way in which this operates in all the lower animals, and often in man, too, we may wonder that it should be almost a matter of routine to remove scabs in surgical practice. It may gratify our curiosity, it may even aid our study at time, but it is often of no advantage to the patient to remove from a disfigured face, or a cut head, the crusts which are nature's reliable antiseptic dressings. From what I have seen, I believe it is best to leave such crusts undisturbed whenever possible, and if they are objectionable, in an æsthetic sense, simply to cover them with something better looking. Further, it may be said that an artificial scab made with lint, or tarletan, or thin muslin, and collodion, forms one of the best dressings for simple incised and not a few lacerated wounds, which have ever been devised.

In hospital practice, I see many cut heads and simple incised wounds, even after the removal of tumors, which go to a prompt and uninterrupted healing under the first dressing of this sort. Similarly, scabs may be formed by allowing lint to become saturated with the oozing of a wound exposed to the air. Dry powders, such as earth or bismuth, or calomel, or powdered borax, or boric acid, or iodoform, may also be used to promote the formation of a crust. In all these cases, however, it is important to watch lest the crust bind down offensive discharges, as any scab may do; when this happens, the crust must, of course, be removed, and the wound cleaned.

In the case of strumous ulcers and the weak granulations of large burns, I have had the happiest results from setting aside ordinary dressings, and applying a powder in this way. In these latter cases, I have sometimes practiced exposure of the granulating surface to the air until the serous film covering them has coagulated and formed a species of skin over them. And to my astonishment, I have seen such a film actually transformed into thin skin without displacement. This is a fact which I believe does not accord with the accepted laboratory idea of new skin formation; but it is a fact, nevertheless. And I would especially urge upon others this plan of treatment in the class of cases referred to—old burns and strumous ulcers—which are, I believe, often kept open by the ointments and other warm and moist dressings used to promote their healing.

Water Dressing is another good dressing, which I believe is too little appreciated. I have seen a number of wounds of the fingers and hands, for example, done by machinery, in which rapid and painless recovery has followed the application of wet lint, which was wetted again as often as convenient, with a lukewarm or cool solution of common borax. Patients with such injuries I have often dressed with cold water and told them to dip the finger or hand, as the case might be, in a solution of a teaspoonful of powdered borax in a pint of water, warm or cool, as they found more pleasant, without removing the first dressing.

Lead-water and Laudanum is but little better than cold water, so far as my experience would indicate; although it is suited to cases that are especially hot and painful. But I believe this ought never to be covered up, as it very often is, with impervious coverings. It is not an uncommon thing for me to see a cut hand, or a contused joint, or a painful fracture, covered with lint soaked in lead-water and laudanum, with a piece of waxed paper over this, and next a bunch of oakum, the whole bound to a splint with many layers of bandage. My inquiries have usually elicited, from patients treated in this way, the most expressive assurances that they had suffered much, often having passed a sleepless night after these dressings were applied; and I have, I think I may say invariably, found that the suffering disappeared when I changed the dressing for a light lint, dipped in lead-water and laudanum, and held in place by a thin, light bandage, so applied as to leave part of the lint exposed to the air and consequently to evaporation of the lotion, with no splint at all, or the lightest and smallest kind possible. What makes a recent injury hot and air-proof, I have found usually a painful dressing.

Dilute Alcohol is another refreshing dressing, if it be allowed to evaporate, and removed at the first sign of pain.

Carbolized Oil, which is, perhaps, not such a very common surgical dressing nowadays, I have found to become very quickly offensive, and I now hardly ever use it. If renewed often enough, it is, however, soothing and healing.

Ointments.—To discuss fully the ointments in use in simple surgery, would require more time

than you have to give me. So I may, perhaps, be justified in stating that the most universally applicable ointment for open wounds which I know of, is one made of equal parts of carbolic acid ointment and oxide of zinc ointment. This has seemed to me to do more good than any other ointment in the case of granulating surfaces, unless they were syphilitic, and in these, I think, mercurial ointments sometimes do better. A little point in regard to the use of ointments is, that they should be confined, as nearly as possible, to the open surface. A piece of lint or muslin should be spread with the ointment, and trimmed down to the exact size of the sore. If spread on the adjacent skin, it will often, after a while, set up an artificial eczema, which is very annoying to a patient.

(*To be continued.*)

EDITORIAL DEPARTMENT.

PERISCOPE.

The Possible Suspension of Old Age.

Dr. S. W. Caldwell thus writes in the *Mississippi Valley Medical Monthly*, March 10, 1885:

In bygone times those profound mysteries and metaphysicians, the Rosicrucians, and still later the Alchemists, claimed to have discovered the elixir of life. They asserted that old age might be retarded and life considerably prolonged by means of an elixir, preventing or rather suspending physical decay. The celebrated English Rosicrucian, Dr. Hood, whose writings became famous, is said to have reached a hundred years.

Modern science has recently made more startling discoveries than were those dreamed of by the alchemist. The possibility of prolonging life has throughout all ages been deemed worthy of notice by great thinkers, amongst whose number the illustrious Bacon and Hufland are enrolled. In the following remarks I shall endeavor to give the latest scientific knowledge relative to this interesting and, in some respects, novel subject. Premature age, as engendered by various mental and physical causes, excesses, etc., do not come within the scope of this short paper. The principal characteristics of old age, as demonstrated by anatomical research, are a deposition of fibrinous, gelatinous, and earthy material in the system. Every organ of the body, during old age, is especially prone to ossific deposits. The earthy deposits have been found to consist primarily of phosphates and carbonates of lime combined with other calcareous salts.

According to the researches of Dr. Williams, of England, man begins in a gelatinous and ends in an osseous or bony condition. From the cradle to the grave a gradual process of ossification is undoubtedly present; but after passing middle age the ossific tendency becomes more markedly developed until it finally ushers in senile decrepitude. These earthy deposits during old age materially interfere with the due performance of function by the organs; hence we find imperfect circulation in the aged; the heart gradually becomes ossified; the large blood vessels blocked up with calcareous matter, and nutrition hindered.

A distinguished physiologist says: "If repair was always equal to waste, life would only terminate by accident." And it is the opinion of eminent scientists that the majority of all who pass sixty-five years suffer more or less from these ossific deposits. Therefore, bearing these facts in mind, we plainly see that the real change which produces old age is in truth nothing more nor less than a slow but steady accumulation of calcareous matter throughout the system; and it is owing to these deposits that the structure of every organ is altered, thus elasticity giving way to senile rigidity. Blockage of various organs thus commenced, and sooner or later a vital part becomes involved, and death of necessity follows. The idea that old age was brought about simply, or at all, by a decline of the vital principle, has long since been discarded by scientists, and the true cause found to be that of gradual disintegration of the tissues because of the inadequate supply of blood.

Again, quoting from Dr. Williams, this process is believed to be of a chemical nature, consisting in the concretion and accumulation of calcareous salts, phosphates, and carbonates of lime. The causes of old age therefore being nothing more nor less than ossific deposits, let us for a moment look for the causes and influences leading to the condition we have described; for having arrived at the predisposing causes of senile decay, it yet remains for us to go still further and seek out their origin.

The two principal causes of old age are, first, fibrinous and gelatinous substances; and second, calcareous deposits. According to recent researches of Delany Evins, the origin of the first, the fibrinous and gelatinous, may undoubtedly be traced to the destruction of atmospheric oxygen, and demonstrable by the following argument:

In the air we breathe the relative proportion of oxygen to nitrogen is 22 to 78; and although oxygen is in far smaller bulk, yet it is the most active element. Now oxygen has an affinity for every other element except flourine; and as oxygen plays by far the most important part in these chemical changes constantly at work in the economy, life itself is but a constant waste by oxidation and reparation by food. In the blood exists albumen and fibrin, themselves resolved into component parts, carbon, hydrogen, nitrogen, oxygen, sulphur and phosphorus. Fibrin, it is claimed, contains one and five-tenths more oxygen than album. Now oxygen converts albumen into fibrin, fibrin itself being but an oxide of albumen. Although unquestionably fibrin nourishes the organs of our body, yet it becomes at times, as we reach the cool and shady walks in the evening of life, accumulated in redundant quantity, blockading the streams of life as doth the chilling winds

of winter the mountain rivulets. There is always a struggle going on in our bodies between accumulation and elimination, and thus it is that the fibrinous and gelatinous accumulations of old age are chiefly traceable to chemical action of atmospheric oxygen.

The calcareous deposits next claim our attention, being proved by anatomical investigation to be peculiarly characteristic of old age. In the human body water forms seventy per cent. of its aggregate weight; in fact, there is not a single tissue but contains water as a necessary ingredient. Now water holds certain salts in solution which become more or less deposited, notwithstanding the large proportion eliminated through the secretions. Nevertheless, it is but a question of time before these minute particles deposited by the blood have a marked effect in causing the stiffness and aridity of advanced life. The reason why in early life the deposit of earthy matter or salts is so infinitesimal is simply because they have not had time to accumulate. Besides providing the requisite elements of nutrition, food contains calcareous salts, which upon being deposited in the arteries, veins and capillaries, become the proximate cause of ossification and old age. Mr. Lewis, an eminent English scientist, in his Physiology of Common Life, says: "Moreover, in food we are constantly introducing different substances which produce variations in the nutrition of the parts. These different accumulations exert their influence in those changes named age, and they culminate in the final change named death."

Having now traced the primary existence of calcareous matter to food itself, it is consequently a subject of no small moment to ascertain the various dietetic articles containing these salts. As a matter of fact everything we eat does contain them to a greater or less degree. The cereals are found most rich in them; so bread itself, the so-called staff of life, except in great moderation, most assuredly favors the deposition of these salts in the system. The more nitrogenous our food, the greater its percentage of calcareous matter; thus a diet composed principally of fruit, from its lack of nitrogen, is best adapted for preventing or suspending ossification.

Moderation in eating must ever be of great value as an agent for retarding the advent of senile decay. Large eaters more rapidly bring on ossific deposits by taking in more than is utilized or excreted, naturally resulting in blockading the vessels and destroying their normal functions. According to the best authority I have been able to consult, the following seem to be the best articles of food as containing the least of earthy salts: Fruit, fish, poultry, flesh of young mutton and beef, because, as before stated, of their being less nitrogenous. Fluids, as part of the diet, is of special import. All well and spring water contains considerable of the earthy salts, and should therefore be avoided, and cistern water used in its stead, because water is the most universal solvent known. Therefore, if when taken into the system clear of foreign matter, it is to that extent the better prepared to dissolve and take up those earthy salts and convey them out of the system. The addition of fifteen or twenty drops of dilute phosphoric acid to the glass of water, and drank three times a day, will add to the solubility of these earthy salts.

The Brain a Composite Organ.

Some thirty-six years ago, by a premature explosion of gunpowder, an iron bar three and a half feet long, one and a quarter inches in diameter, and weighing thirteen and a quarter pounds, was shot completely through a man's head and perforated his brain. This man walked up a flight of stairs after the accident, and gave his account of how it happened. Although his life was despaired of for some time, he developed no paralysis, nor did marked impairment of his intellectual faculties follow convalescence. Eventually he recovered his health. Twelve years elapsed before his death, during which time he worked as a laborer on a farm.

The "American crowbar case" at once became famous. It startled the minds of the reading public, and confounded the medical fraternity. No satisfactory explanation of the remarkable features of the case could be given. Some prominent medical men pronounced it "an American invention," and laughed at the possibility of such an occurrence. The skull was exhumed, however, after death, and is to-day in the medical museum of Harvard University.

This case may be said to have been the starting-point of a new epoch in medical science. It rendered untenable all previous hypotheses that had been advanced regarding the organ of the mind. It proved conclusively that little, if anything, was known at that time respecting the architecture of the brain of man, and the functions of its component parts.

Since then a large number of observers have published the results of various forms of experiments upon animals, made with a view of determining the physiology of the brain; but for some years the conclusions drawn from such investigations were contradictory, and nothing was definitely established. We now are aware that serious defects existed in the early methods of research. By great ingenuity these have been gradually eliminated. We owe, however, to the discoveries of Türck, Fritsch and Hitsig, Waller, Flechsig and Gudden, most of our knowledge of new methods of research which have simplified the study of the nervous system during life and after death. These have settled many points in dispute. They have also made our knowledge more accurate, and in accord with clinical observations.

The last decade has enabled us to bring most of the results obtained by vivisection into perfect harmony with pathological data. Those who have claimed that conclusions drawn from experiments upon animals are not applicable to man are to-day confronted with unanswerable facts to the contrary. Nature, through the agency of disease processes, is constantly performing experiments upon human brains, and the symptoms so produced may be recorded during life, and compared with the changes found in the brain after death. Physiology and pathology have thus added much to our knowledge in this field.

To-day the "crowbar case" is no longer a mystery to specialists in neurology. Bullets have been shot through the brain since then without loss of motion, sensation, or intellect; and in some cases they have been known to remain buried in the brain substance for months without

apparent ill effects. Three years ago a breech-pin of a gun, four and three-quarter inches long, was forced into the brain of a boy nineteen years old, through the orbit, and its presence was not suspected for some five months. It was discovered during a surgical attempt to repair the facial deformity that resulted from the accident. Death followed the removal of the foreign body from the brain, in consequence of inflammation, created apparently by its extraction. This case is quite as remarkable as the crowbar case, but it excited less interest in neurological circles, because we are in possession of new facts.

We know to-day that if even a needle be thrust into one region of the brain (the medulla oblongata), immediate death may follow, while a crowbar may traverse another portion of the organ and recovery be possible. The effects of injury to the brain depend rather upon its situation than its severity.

In the light of our present knowledge the brain must be regarded as a composite organ, whose parts have each some special function, and are to a certain extent independent of each other. One limited part is essential to vital processes; hence its destruction causes death. Another part presides over the various movements of the body; hence paralysis of motion is the result of destruction of any portion of this area. A third part enables us to appreciate touch, temperature, and pain; and some disturbance of these functions will be apparent when this region is injured or diseased. A fourth region presides over sight; blindness may follow disease or destruction of this area, in spite of the fact that the eyes escape. In the same way smell and hearing are governed by distinct portions of the brain, and also the sense of taste. When a combined action of different parts is demanded—as in the exercise of the reason, judgment, will, etc.—the knowledge gained by means of the special senses can be contrasted and become food for thought.

The skilled neurologist can often tell to-day, by the symptoms exhibited during life, the situation and extent of disease processes that are interfering with the action of certain parts of the brain. So positive is the information thus afforded in many cases, that surgical operations are now performed for the relief of the organ. A patient who had lost the power of speech from an accumulation of pus within the brain, was lately cured by the removal of a button of bone from the skull over the seat of the pus, and its prompt evacuation. Epileptics who suffer in consequence of brain irritation may sometimes be cured of their fits by the mechanical removal of the cause Paralysis can occasionally be cured by a removal of a clot of blood from the surface of the brain through a hole in the skull. Only a few months ago a bullet, which had been shot into the head during an attempt at suicide, was removed from the skull, in one of our hospitals, by means of a counter-opening. The labors of such men as Meynert, Charcot, Nothnagel, Ferrier, Wernicke, and others, have made neurology a science that would exceed the comprehension of its founders. Our ability to localize disease within the substance of the spinal cord is even more remarkable than in the case of the brain.—Dr. A. L. Ranney, in *Harper's Magazine for March.*

Bilateral Athetosis.

Dr. A. G. Barrs thus writes in the *London Med. Times*, January 31, 1885:

Examples of the conditions first-named by Hammond, are of sufficient rarity to warrant the publication of the following case:

F. G., a female aged 36, was seen by me at the Leeds Public Dispensary, on November 19, 1884.

She is married, and has had one child born thirteen years ago, which survived its birth only six months, and then died from simple wasting, and without any manifestations of congenital syphilis. There has been no subsequent pregnancy, and her husband is living and well. Thirteen weeks after her confinement, which had passed without any difficulty or subsequent puerperal trouble, she was suddenly seized with paralysis of the right limbs, and loss of speech in the ordinary hemiplegic fashion. There was no loss of consciousness. For some little time preceding the stroke, she had experienced a slight sensation of numbness in the tongue and roof of the mouth. The movements in the left hand made their appearance slowly soon after the paralytic seizure, so far as she can now remember, and have been constant ever since.

F. G. is a pallid, spare, rather haggard-looking woman of clear intelligence, but slightly emotional. One is at once struck with the constant grotesque movements of the fingers of the left hand, which she is continually trying to restrain, but only partially succeeds in doing so, by grasping them firmly with the other hand, and placing both between the knees. The forearm and hand on the left side seem also to be affected, and when standing she controls their movements to some extent by grasping the folds of her dress. The movements have precisely the grotesque, irregular, involuntary, slow, and apparently powerful character described by Hammond, the abduction and hyper-extension of the individual fingers being well marked. On further and closer inspection, it is seen that the movements are not confined to the left hand. The little finger of the right hand presents the abducted and hyper-extended position to a well marked degree, and the other fingers of this hand have constant movements of the same kind, but to a much less extent than those on the opposite side. The toes of both feet show the slightest disposition to move involuntarily when placed in any definite posture.

The right arm on actual measurement shows a slight loss of substance when compared with the left. After very careful testing, no anæsthesia is found in any of the affected parts.

The mouth is markedly drawn to the left side, and the right face presents the ordinary condition seen in hemiplegia. The muscles of the left side of the face are undoubtedly affected by the athetotic conditions, and are continually manifesting slow movements giving rise to curious grimaces. The tongue is, when protruded, strongly deflected to the right, and markedly unsteady. While projecting from the mouth, the organ is seen to be firmly grasped by the lips, which perform a sort of sucking movement upon it. There is no obvious affection of the neck muscles.

The constant movements of the hands interfere surprisingly little with the performance of her

ordinary household duties. After being asked to make careful observation, the husband states that the movements in the left hand, though much diminished, do not entirely cease during sleep. The heart sounds are clear. The urine has a sp. gr. 1015, and is free from albumen or sugar.

The case is one of very striking interest as combining in one individual a spontaneous and a post-hemiplegic motor affection in no way to be distinguished from that described by Hammond under the name of athetosis. So far as I am aware, no attempt to set apart cases of spontaneous athetosis from the large class of post-hemiplegic movements was made until Oulmont* published his thesis in 1878. Cases of bilateral and spontaneous athetosis had been published by Dr. Claye Shaw, Dr. Clifford Allbutt, and Professor Gairdner previously, but had apparently been regarded as much the same nature as the post-hemiplegic cases. In regard to the case here published, it is difficult to determine off-hand whether it is one of spontaneous double athetosis, the affection of the left side being much in advance of that of the right side, or one of primitive hemi-athetosis of the left side, with a late development of ordinary post-hemiplegic movement on the right side.

We have the authority of Charcot, and with some qualifications of Dr. Gowers, for regarding such cases as those published by Hammond and all such, as examples of one of the rather numerous classes of post hemiplegic motor disturbance —as example, in short, of what has for long been known as post-hemiplegic chorea. But even here two well-marked classes of cases are to be found, namely, those in which the affected limbs are anæsthetic, and those in which sensation is unaffected. Again, the absence of any strictly paralytic condition in the present and in many other published cases of athetosis points to its being an unusual sequence of ordinary hemiplegia. The case here published, together with those of Oulmont and others, goes far to establish a considerable class of cases in which slow, irregular, involuntary, contortions of certain members, especially of the hands, are altogether independent of any anterior paralyzing lesion or lesion of the sensory tract. What may be the true nature of this class of cases, and what their pathological substratum, there is little evidence upon which to base an opinion. From a clinical point of view, though easily distinguished from, they have a close resemblance, in kind at any rate, to ordinary chorea. Very little pathological evidence is forthcoming in explanation of the primitive, as distinguished from the post-hemiplegic cases; but, such as it is, it points rather to a so-called functional derangement in the motor area of the cortex of the brain than to any structural change which we can at present recognize. A case recently published by Kirchoff, of mitral disease, in which athetotic movements of the left limbs appeared and continued up to death, 22 days later, and in which no brain lesion was found, either embolic or otherwise, tends to support the conclusion which the clinical manifestations seem to me to favor: that the primitive or spontaneous athetosis is not due to any organic change in the motor centres, but to their functional disturbances or obliquity.

*"Étude Clinique sur l'Athetose," Paris, 1878.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——That contaminated drinking water is the commonest cause of typhoid fever, and that low water in wells means contaminated water, are strongly set forth in a pamphlet by Dr. Henry B. Baker, of Lansing, Mich. He adds this among other useful suggestions:

"The numerous instances where typhoid fever has apparently been caused by drinking-water contaminated by decomposing *vegetable* matter, indicate that, even if the cause of the disease is specific, until such time as that the specific cause shall be so restricted as not to find access to water-supplies, it is important to preserve the water from contamination by vegetable as well as by animal matter."

——The extension of our railway system towards and into Mexico has been one of the most remarkable developments of recent years. A paper, "Along the Rio Grande," by Mr. Sylvester Baxter, which appears in the April *Harpers*, will give an entertaining sketch of that country before and during the making of the railway there, and many illustrations by W. L. Metcalf will add to its interest.

BOOK NOTICES.

Lectures on Diseases of the Nervous System, Especially in Women. By S. Weir Mitchell, M. D., etc. Second edition, revised and enlarged. With five plates. Philadelphia: Lea Bros. & Co.

The second edition of this work appears with considerable changes from the first, several of the lectures having been rewritten, and others added. The latter are on the difficulties of diagnosis in hysterical diseases of joints, on the relations of hysteria to organic disease of the spine, and on hysterical disorders of the rectum.

These, and the other topics treated by the author, which include hysterical paresis, the mimicry of disease, tremor, chorea, disorders of sleep, hysterical aphonia, and similar affections, are discussed with great acuteness of observation, and faithfulness of clinical portraiture. The many obscurities which surround this class of diseases are explained, and the various plans of treatment discussed. The volume cannot fail to prove a satisfactory one to the reader.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

ISSUED EVERY SATURDAY.

D. G. BRINTON, M. D.,
JOSEPH F. EDWARDS, M. D., } EDITORS.

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THE

QUARTERLY COMPENDIUM

OF

MEDICAL SCIENCE.

The attention of our readers is especially called at this season to the ***QUARTERLY COMPENDIUM,*** which we publish.

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WHAT INSANE ASYLUMS SHOULD BE.

There is an evident reaction on the part of some leading alienists against the theory so generally advocated a few years ago that the insane are best cared for in enormous single structures.

The ghastly accident of fire, of which we have recently had a terrible example in this city, is one reason why we should hesitate to crowd hundreds of people bereft of their reason into one building. More than any other class they are unable to care for themselves in such an emergency.

But apart from this, there are other good grounds for objecting to these vast edifices. Such objections are well set forth by Dr. H. Wardner, Superintendent of the Southern Illinois Hospital for the Insane, in a paper read before the tenth annual Conference of Charities and Corrections, held at Louisville, Ky., September 24–30, 1883, and recently printed.

He points out that the time has come for alienists to recognize the fact that the chronic insane should have daily employment at some obviously useful work. Most of them would be better and happier, too, if more simply housed in smaller masses than at present. In other words, most of them need to live more natural, more industrious and more responsible lives than they do or can under the existing system, and conditions of greater healthfulness and comfort may be found, we are convinced, in a system looking toward the less costly management of asylums.

Instead of immense buildings, he would have large farms, with several, or a number of small residences. At least an acre of ground should be assigned to each inmate. There is, as he observes, ample testimony to show that the insane feel the need of precisely what it is here sought to give them, namely, a more natural daily life, free access to the open air, a sense of release from restraints of asylum life, earnest work, and a qualified responsibility for themselves and their support.

The details of such a plan would be for the state to buy such farms in healthy locations, and upon them have built structures of moderate size and cost, well ventilated and drained, and placed at

convenient distances from each other. In these buildings the chronic insane can be housed at much less cost than at present, with greater freedom of access to the air and sunshine at all hours. The able-bodied men should be expected to cultivate the land in farm and garden crops suitable for the maintenance of the institution. Those who understand mechanical trades should be set to work at them, chiefly at asylum work.

The women can be employed at ordinary women's work—household labors, sewing, etc. In brief, all the patients should be made to live as nearly as possible after the manner of sane people, each group constituting a household, under the general charge of proper attendants, in which the inmates may live comfortably rather than luxuriously, while contributing by their labor to their own support.

There is sufficient experience already to be certain that a scheme of this nature is entirely practicable; and if the plan is ever generally adopted, experience from year to year will point the way to its gradual perfection in details.

WINTER HEALTH RESORTS.

The tendency among the well-to-do classes is, year by year, setting towards the idea that "all work and no play makes Jack a dull boy," and it is one of the most gratifying evidences of our advancing civilization that our people are commencing to realize that brief seasons of rest and recreation from the more earnest, serious, and arduous duties of life, are not only necessary, but are to be regarded as real sources of pleasure. There was a time when our merchants seemed to delight in boasting that they had not been away from their desks for a day in the past "three or four years." But happily this *barbaric* boast is a thing of the past, and it is now customary not only to see our business men passing the summer away from the city and taking frequent days "at home," but also is it not uncommon to find them "running off" for a few days in the winter. When this practice becomes more common we will hear much less about "neurasthenia," and "American dyspepsia," and our offspring will be infinitely less "*dudish*."

We know that the highly-strung nerves of the large merchant, or the literary man, must be occasionally unstrung, else they will fail ultimately and prematurely to the demands that are made upon them. We know that absolute change of scene, surroundings, occupation, and habits, is the surest means of resting the wearied brain and the exhausted body. Year by year the travel, in winter, to southern climes is on the increase among those whose worldly possessions afford them the leisure to so elect.

Indeed, but recently, a prominent physician remarked that, in his opinion, Florida was the only State in the Union fit to live in. While we cannot go this far, yet we can and do most emphatically assert that in such a trying climate as ours, occasional trips to some more equable climate are productive of wonderfully beneficial results. For the convenience of those who cannot spare the time for a lengthy absence from business, we have dotted along the Atlantic coast of New Jersey from Long Branch to Cape May Point, a perfect host of delightful resorts, to which the weary, brain-sick city man may take himself, and soothed by the roar of "Old Neptune," and invigorated by that almost indefinable something which is ever present in salt air, regain and retain that vigor so necessary not only to happiness, but to the proper prosecution of his duties.

Of course, "variety is the spice of life," and "change" of any kind is beneficial, but there certainly does seem to be an especial virtue in the air of the sea-shore, especially in winter.

The hotels at these various resorts are all provided with every appliance for the comfort and pleasure of visitors, be they invalids or not. We find enclosed porches, with glass sides, through which the sun pours its rays, so that even in the coldest weather one may have a sufficiency of wholesome exercise. We find good eating, polite attendance, and all that may go to make one happy and contented.

At some of these hotels (we noted it personally

at Cape May Point) a resident physician is always in attendance, which in itself is a great inducement for invalids, giving them a feeling of security. Our most recent experience with winter sea-side resorts was at Cape May Point. This little settlement is located at the southern extremity of New Jersey, just where the Delaware Bay empties into the ocean. It possesses many natural advantages, and when the facilities for reaching it are improved, it will become a popular winter resort. We have written these few words to call the attention of our readers to the growing popularity of these winter sea-side resorts, and to suggest that both for themselves and their patients a few days every now and then passed in this way will not be time lost.

Notes and Comments.

Foreign Body in the Alimentary Canal of an Infant Ten Months Old—Passage in Thirty-Six Days—Recovery.

A recollection of such cases as the following will, no doubt, serve on occasions to help us out of tight places. Dr. F. W. E. Kinneir reports it in the *Brit. Med. Jour.*, March 15, 1885:

On January 15, I received an urgent message to go and see a baby, who, the messenger said, had swallowed a toy, and was choking. On my arrival at the house, the father of the child told me that, just after the messenger had started, the child became so bad that he thought it would die; he therefore passed his finger into its mouth, and, feeling something hard and sharp, and not being able to remove it, he pushed it down. The little one was at once relieved, and, when I saw it a few minutes afterwards, was quietly taking the breast as if nothing unusual had happened. I kept the child under observation for a day or two, and gave directions that the motions should be watched and examined. No bad symptoms whatever occurred, the child taking the breast and sleeping as usual. The circumstance had nearly passed from my memory, when, on February 20, thirty-six days after the infant had swallowed the foreign body, the father came to my surgery, and said that the baby had just passed it. The baby seemed in a little pain as the motion, which was semi-solid, came away, and the diaper was slightly stained with blood. The foreign body proved to be half a brass toy locket, with sharp cutting edges, measuring in its long axis seven-eighths of an inch, and from side to side nearly three-fourths of an inch. The color of the brass was very little altered.

The above case seemed to me to be interesting on account of the length of time the foreign body remained in the alimentary canal, no untoward symptoms occurring during its passage. In an adult, we can administer opiates, keep the patient at rest, and order him constipating food, so as to form a coating or a vehicle for the foreign matter swallowed; but this treatment is impossible in an infant ten months old, subsisting, as my little patient does, only on its mother's milk.

Mr. Erichsen relates an interesting case, in which he succeeded in getting a gold plate with three molar teeth to pass in four days after it was swallowed by a gentleman 25 years old; but I think, in contrasting the two cases, that of my little patient is of greater interest.

Ipecacuanha in Dysentery.

It is interesting to learn something about the history of the use of this drug in dysentery, since it has come to be so generally used. Hence we extract the following from Dr. Macpherson's address before the Medical Society of London (March 9):

The drug was introduced into European practice during the last decade of the seventeenth century, as a remedy for the bloody flux; in this malady it acted like a charm. Helvetius considered it as specific in dysentery, as mercury in syphilis, or cinchona in malaria. After being highly prized for about half a century it fell somewhat into disfavor in England and France; but it was habitually used in small doses until the end of the last century. Akenside used very small doses—one grain every six hours; but other physicians recommended either one large dose or several smaller ones (five grains), repeated every hour until vomiting was produced. Subsequently very large doses, even frequently repeated, were highly favored in the tropics, but it was almost entirely superseded by mercury as a remedy for dysentery, though never quite abandoned. In 1846 Dr. Parkes said that ipecacuanha was of quite secondary importance, but recommended small doses. Sir Ranald Martin used doses of ten grains at least. Since 1858 the use of ipecacuanha has been the main feature in the treatment of dysentery, and though something must be put down to improved hygiene and the abandonment of bleeding, still the diminution of the mortality among the troops pointed to the probability that the

drug was really of use in saving life. The French also now use the drug in large doses in the tropics and in America. Bartholow and others had found it useful. From a consideration of the general experience, he was inclined to say that the dose should not exceed thirty grains nor fall below five. He referred to the temporary popularity of mercury during the first half of the present century, and mentioned that even scruple doses of calomel were at one time commonly given, and were supposed to have a specific action on the mucous membrane in dysentery. Ipecacuanha had now entirely replaced it.

A Method of Averting Syncope.

It is well that we should always be prepared to avert what may or may not prove to be a serious, or even fatal, syncope. In persons whose hearts are weak, fainting or syncope is not at all uncommon, and may be produced by very slight causes. Hence we reproduce the concluding paragraph from an article on the subject by Dr. William J. Notley, in the *Lancet*, March 14, 1885:

"Now, in all cases where the syncope is not complete, and where the heart continues to act, though feebly, measures are taken to restore the patient by adopting such means as are calculated to strengthen the action of the heart and facilitate the flow of blood to the brain. In many cases a person accustomed to faint from slight causes will be able to avert the syncope by adopting such means, and it is for this purpose that I wish to draw attention to the efficacy of heat applied to the head. In a person with a weak heart, syncope may be produced by simply sitting with the feet in hot water, and, in like manner, it may be averted by application of heat to the head. Anyone may convince himself of this by first producing faintness in himself artificially. This may easily be done by getting into a bath of about 110° F. In a few minutes he will begin to feel faint. Let him then plunge the whole of his head except the nose and mouth beneath the surface of the water, and in less time than it has taken to bring on the faintness all the disagreeable sensations will cease, and he will now be able to continue in the bath, perhaps for half an hour longer, without any inconvenience. From this it would appear that the application of heat to the head is a measure of some value in averting a threatened attack of syncope."

Remarkable Re-Implantation of a Tooth.

The *London Medical Times*, February 28, 1885, tells us that Dr. Bestion relates (*Gazette des Hopitaux*, January 17,) a case which is probably unique as regards the length of time in which a tooth remained without replacement, after being forced out of its socket. A sailor while engaged in securing a vessel placed the rope in his mouth in order to have a hand free. A comrade inadvertently tightening this rope forced out upon the deck the lower left median incisor tooth. After some searching the tooth was found, but it was not until seventeen hours after the accident that the sailor related his adventure to Dr. Bestion, producing his tooth in a state of absolute dryness. After soaking it in water for a few minutes and then drying it, Dr. Bestion replaced it, the operation causing pain and some hemorrhage. The tooth keeping in pretty straight, no bandage was applied, the only precaution taken being to substitute for the biscuit, soft bread, which for the early days was moistened with water or wine. At the date of the report, that is to say, three months after its replacement, the tooth was found to be quite solidly in place, the only change observable being a diminution of the brilliancy of the surface. Dr. Bestion cannot find any case on record in which a tooth had been successfully replaced after a later period than four hours had elapsed. This is related by Magitot as occurring in a child ten years of age. This author also relates several examples of this time having elapsed in his operations in which the tooth has been intentionally drawn and replaced after the diseased parts had been excised. He also relates the case of a laborious removal of a wisdom tooth, that necessitated the preliminary extraction of the second molar, which was re-implanted about four hours after the operation.

Carbonate of Ammonia in Scarlet Fever.

Dr. A. W. Jackson, of Brooklyn, writes to the *Med. Record*, calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart, of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition, he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation, a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.

SPECIAL REPORT.

PROGRESS OF OTOLOGY.

BY LAURENCE TURNBULL, M. D.,

Aural Surgeon Jefferson Medical College Hospital; Instructor in Otology, Post-Graduate Course.

The following recent articles on otology have been received since our last review* on this subject:

A Case of Symmetrical Defection of the Hard Palate.† This rare case of anomalous formation was reported by Dr. A. Schapringer, of New York, at the scientific meeting of German surgeons of that city, September 26, 1884. Emilie Sch., a seamstress, 26 years old, and unmarried, was born in New York, of German parents, who are both living and in good health. In her early youth she experienced a very severe attack of diphtheritis. Her voice since that time has been very hoarse, and in the last few months the hoarseness has increased, also a worrying cough, with frequent vomiting, fever, and loss of power have appeared, on account of which symptoms she stopped work. An examination showed two symmetrical, vertical, long oval openings in the hard palate. The right, large enough to run the point of the little finger through with ease; the left a little smaller. The mucous membrane of the opening was normal, and showed no trace of scar. The patient knew of the presence of these openings from her childhood. The tonsil of the right side was wanting, and on the left it was found in rudiment. The largest part of the mucous membrane covering the posterior wall of the pharynx was a web of scars, changed evidently by the diphtheria. The laryngoscopic examination was incomplete on account of the intensity of the break of the inclination. It showed ulcer formations on the real vocal cords.

From both nostrils ran a shallow furrow a short distance vertical upon the upper lip. The furrow on the left side was more distinct than the right. Both sides of the hare-lip healed intrauterine. No difficulty in swallowing has been mentioned by the patient.

The formation of the opening in the arcus palato-glossi is yet to be explained—perhaps it will be given to us earlier from comparative anatomy than from embryology.

2. *Round-celled Sarcoma of the Ear.* By J. Orne Green, M. D., of Boston. The case is interesting, as growths of this character are rare in this situation. The patient was a young man, 23 years of age, entered the Boston City Hospital November 29, 1882. There had been an otorrhœa on the left side ever since scarlet fever at six years of age, continuous and without acute exacerbations. When first seen, the left meatus was filled with a spongy, very vascular, fleshy mass, and there was a muco-purulent discharge. There was slight pain, which after a time increased to the mastoid, followed by redness and swelling of the integument. The diffuse swelling over the mastoid ruptured after entering the hospital, and from the opening protruded a mass of fungous granulations two inches in length and one in breadth, dotted with spots of sloughing tissue, and bleeding freely on touching. The general condition of the patient was very bad, anæmic, and very weak: pulse and temperature but little above the normal. The treatment was iron, quinine, and stimulants, and a charcoal poultice.

On removing the fungous granulations over the mastoid, after etherizing the patient, carious communications were found to exist between the meatus and mastoid, and the petrous bone was found in the same carious condition. In forty-eight hours after treatment there was an improvement but was followed by a relapse with an increase of bad symptoms. February 26th, a paralysis, of the left facial was noticed which continued through life. The tumor increased in size to eight inches in length, six in breadth, and four in thickness over the mastoid, it extended below and in front of the auricle. The treatment consisted in draining the deeper parts, antiseptic dressing, nourishment and stimulants and morphine for the pain. Death from exhaustion took place May 21st.

A microscopical examination of a portion of the tumor by Dr. W. W. Gannett, Pathologist of the Hospital, reported, "a sarcoma of the round-celled variety."

3. A pamphlet, on "*Naso-Antral Catarrh and its Treatment*, By W. H. Daly, M. D., Pittsburgh, Pa. Reprinted from the Archives of Laryngology, Vol. iii. No. 4, October, 1882. He reports two cases with, a "hope that more light may be thrown upon the subject of, not only, the extension of purulent catarrhal disease to the antrum of Highmore and its efficient treatment, but upon the more difficult problem of similar affections of the frontal sinus, the nasal ducts, and the ethmoidal cells." In a case of this character, the patient

*Progress of Otology, MED. AND SURG. REPORTER, November 1-8, 1884.

†Reprint from the Monatschr. f. Ohrenheilk. so wie für Nasan-Rachen-Kehlkopf, and Luftöhren-Krankheiten, No. 11, 1884.

was first attracted by a pain about the left eye, of greater or less severity during two or three months. This pain subsided after a copious purulent discharge from the left nostril. From the nature of the case, there was no suspicion of disease of the antrum, at first; however, after three months' most obstinate efforts on the part of the patient and the doctor, he determined that a large part of the discharge came from the left antrum of Highmore. He was led to this conclusion by the patient telling him that latterly, when lying on his right side, an occasional free flow of mucopus would come into his throat, but no pain existed in the region of the antrum.

The second bicuspid tooth was extracted, and by means of a drill the antral cavity was easily entered. In order to verify the diagnosis, the nasal cavities were thoroughly washed out; then the nozzle, attached to a common Davidson syringe, was placed in the opening of the jaw and a simple alkaline fluid forced in. This was attended immediately by a copious flow of thickish, rather offensive mucus from the antrum, through its orifice into the nasal cavity. This was daily thereafter observed by means of the nasal speculum.

"That this case was fully cured, I am unable to say, but that the disease of the antrum was cured, there is scarcely a doubt."

4. "*The Diagnosis and Treatment of Chronic Nasal Catarrh**." By George Morewood Lefferts, M. D., Prof. of Laryngoscopy and Diseases of the Throat in the College of Physicians and Surgeons, New York, etc. This is a little book of 49 pages, with numerous woodcuts, and is divided into three clinical lectures—1. Examination; 2. Diagnosis; 3. Treatment.

We all hear a great deal about "chronic catarrh of the nose," and you will see a good deal of it. Patients who suffer from it, and patients who have not got it, but imagine that they have, will come to you in great numbers. You certainly, then, ought to be able to recognize it when present, to exclude it when absent, and above all, be competent to treat it scientifically and successfully. Let me ask just here: do general practitioners always recognize it? Do they always examine for it? Are they not too apt, in too many cases, to accept the statement of the patient, make no examination, prescribe a nasal douche and some wash, and allow the patient to disappear, perhaps to excite a catarrh where none existed before? Patients will make their own diagnosis—it is common for them to do so—and often come to you for the treatment of that which perhaps does not exist; often they will treat themselves, without any advice. The country is flooded with advertisements, pamplets, and books on the subject of nasal catarrh. The field is a rich one for the quack; "sure cures" multiply rapidly; new remedies are eagerly sought for by the credulous; "catarrh snuffs" crowd the counters of every drug store, and "nasal douches" are manufactured and sold by the thousand. The quack does not spare the feelings of the patient: he pictures the disease in its most disagreeable aspects; he dwells upon the worst symptoms; he confounds other diseases—syphilis, for instance—with simple catarrh; in short, he frightens.

Your patients, then, well posted on literature of this class, come to you, dreading that the nasal trouble that they have, or perhaps have not got, will develop into the worst form of catarrh that they have read about—above all, that it will develop a disagreeable odor. A symptom that they also often dwell upon, regarding it as a sign of the dread disease, is "a constant dropping of mucus in the throat"—an ever present desire to clear it. Some little mucus they do bring away, often not. Let me warn you here, that in a good percentage of these cases all this has nothing to do with "nasal catarrh." The patient is probably suffering from a simple relaxed throat, or a chronic pharyngitis in one of its forms—perhaps, and most commonly, a relaxed or elongated uvula—and that these, especially the latter, are the matters at fault, *not* the nose. All this you must prevent, they cry to their doctor; they demand treatment at your hands.

Now, much of this nonsense you, as sensible medical men, can prevent. But, first, you must yourself know what nasal catarrh really is, what forms it appears under, and how to recognize the varieties by their intra-nasal appearances. The day has gone by when all nasal affections can be recklessly classed under the generic name "catarrh," and so treated. What a multitude of sins that word has covered!

The one symptom that patients most fear, and justly so, I have already alluded to: the foul smell from the nose; but it is in reality a rare one, and only occurs in the fetid or atrophic form of nasal catarrh. It only occurs in patients who are the victims of syphilis or struma, sometimes happens in scrofulous subjects. Fetid or atrophic catarrh is unusual, and thus you are able at once to reassure your patient in regard to the most dreaded symptom.

*Reprint from Med. News of Philadelphia, April 26, and May 3, 1883, and American Clinical Lectures, Vol. ii., No. vi. Lambert & Co., St. Louis, Mo.

I have said this much in order to prove to you the necessity of learning to recognize the varieties of nasal catarrhal disease, for not alone diagnosis, but, what is equally important, your correct views regarding the questions of prognosis and treatment, will depend upon your acquirement of this knowledge. Some forms of nasal catarrh are curable, others are not. Is there, then, more than one form of nasal catarrh? Most certainly; and you will learn to differentiate them. First, acknowledge the fact that they do exist. You will meet with three varieties: 1. Simple chronic rhinitis (and let me say here, that I prefer this term rhinitis to the one "catarrh," which is so commonly used). 2. Hypertrophic rhinitis; and 3. Atrophic, or fetid rhinitis.

In the treatment of nasal catarrh, the patient is frequently misled that the use of the douche will produce a cure. Such practices are productive of no good, but much harm. A chronic inflammation of the delicate mucous membrane is often produced by the use of strong saline solutions in large quantities, passed through the nares under high pressure. While cleanliness is essential, mechanical means for attaining it are to be used with great discretion. There is nothing curative in their employment. All instruments for cleansing purposes, including the nasal douche with its many modifications, are only to be used in exceptional cases of aggravated catarrhal inflammation, with accumulated hardened secretions. The nasal spray apparatus, which throws a *very coarse spray* in the right direction into the anterior nares, is to be preferred.

The doctor concluded by saying, the time will not have been misspent, and the purpose of his lectures will be accomplished, if he has succeeded in convincing his hearers that *all* is *not* simply "nasal catarrh" that comes into their net, although his remarks were necessarily drawn out to some length, and occupied some time.

5. Another pamphlet, on "*Aphonia Due to Chronic Alcoholism, Paralysis of the Lateral Cicro-Arytenoids*," by Ethelbert Carroll Morgan, M. D., Washington, D. C., Clinical Professor of Laryngology in the Medical Department of Georgetown University, etc. Reprint from Journal American Medical Association, December 6, 1884. "There is no morbid condition involving the vocal organs possessing a more varied pathogeny than paralysis of the lateral cicro-arytenoid muscles, the functional aphonia of pre-laryngoscopic authors." It is a fact, generally admitted and frequently observed by the laryngologist, that motor disturbances of these muscles are the result of reflex influences of various diseases: anæmia, chlorosis, dysmenorrhœa, intestinal irritation,* rheumatism,† syphilis, diphtheria, hysteria, deafness, fright, and mental emotion. Palsy of the laryngeal muscles has been caused by lead,‡ arsenic,‖ phosphorus, opium,§ belladonna.¶

"The influence of certain substances taken in poisonous doses is exerted on the nerves and muscles of the larynx, as well as other parts, and loss of voice is a circumstance to be witnessed after using some powerful narcotics, antimony, mercury, arsenic, and other poisons of an exhausting character." Dr. Morgan gives the clinical history and data of two cases of laryngeal palsy, the result of habitual and excessive use of alcoholic stimulants.

6. An article *On the Different Kinds of Subjective Aural Sounds and Their Treatment*, by Dr. Ladreit de Lacharrière, in The Annals des Maladies de L' Oreille, du Larynx, etc., and published in the Journal of the American Medical Association, November 1, 1884, treats of the various types of tinnitus aurium produced in the different parts of the ear, giving the various characters and causes of these sounds, which are so annoying and distressing to the patient. Schwartz was the first to recognize the relations between these sounds and certain forms of mental disease characterized by hallucinations of hearing. In 1869, he, with Kopp, examined ninety-seven cases of insanity; forty-one were troubled with ear affections; that is, subjective sounds and acoustic illusions or hallucinations; twenty-six were affected by noises without deafness; six had hyperæmia of the handle of the malleus; eighteen had hallucinations without noises; twenty-two presented none of these symptoms. Besides these subjective sounds, there are others due to true sonorous manifestations in the interior of the body, as the vascular sounds from alterations in the blood, as chlorosis and anæmia, and in aneurism of the basilar artery. According to Hirtl, there is in man a capillary which passes to the promontory. Might not affections of the tympanum frequently induce alterations in this vessel? M. Lacharrière has frequently relieved patients of pulsatile sounds by compres-

* Voltolini, Wochenschr. f. d. ges Helk., Berlin, 1845, p. 454-59.

† Ziemssen's Cyclop. Pract. Med., vii., p. 946.

‡ A. H. Smith, N. Y. Med. Jour., 1873, xviii., p. 412.

‖ C. E. Sajou's, Arch. Laryngology, vol. iii., I. p. 58.

§ Andral, Cours de Pathologie Interna, Par. 1836, i., p. 316.

¶ G. D. Gibbs, Diseases of the Throat and Windpipe, London, 1854, p. 102-4.

sion of the external carotid. "The application of the continuous electric current is beneficial, particularly in passive congestion from vascular atony; it excites contractility and causes blood stasis to disappear."

(*To be continued.*)

CORRESPONDENCE.

A Mare's Nest—with Eggs.

EDS. MED. AND SURG. REPORTER:—

My dear old friend Dr. Corson is, I am compelled to say, just a little tart in his opposition to Professor Horatio C. Wood on the temperance question. Temperance *in all things* is a good, yea, an admirable moral principle; but may there not be such a precept as *intemperate temperance?* and in this category I am constrained to view the pungent remarks aimed at the distinguished gentleman who stated that for the aged some form of alcoholic stimulant, taken at meals, was requisite to sustain the flagging powers and support a healthy digestive process and assimilation. Through this esoteric force the heart's action also is aided, though not unduly, to propel the vital current to the remotest portions of the frame, imparting to the whole man a vigorous but healthful rejuvenation. He gives statistics from the "Society of Friends," to sustain his objections, and the ages of persons in advanced life who lived and died without resorting to this exoteric power. Probably the Doctor is aware that the numbers of that "Society" are very small as compared with other Christian sects: and were time permitted I could adduce many, very many, more, from other religious denominations, as well as of those not sectarian, who are as free from intemperance of both eating and drinking as the Quakers, who have lived to an advanced age, in numberless instances much beyond most of those the Doctor quotes, under the daily employment of this aid to the enfeebled frame. That intemperate eating has caused more disease and death in the world than intemperate drinking, has long been a recognized fact; and what other sect is known to indulge more freely in this respect than the Doctor's pets? I was not aware until now that it was the proper thing to attach ideas of the "pure and undefiled" of earth as specially pertaining to one sect.

There are doubtless many good men and women, particularly the latter, among this denomination as among others, but they are not all paragons, and why they should be singled out from the "world's people," is an enigma, hard to unravel, for it has been my unfortunate "experience" through life to encounter more guile, to use no harsher term, beneath the sly, specious cant and garb of sanctity, than poor human nature exhibits on a broader field. To point the moral, it is only requisite to peruse and ponder the historical proofs of Billy Perno's characteristics, recorded by Macaulay.

But the question remains, is it sound doctrine to advance the teaching the professor assumes, and give stimulants to the aged, whose vital powers are impaired or flagging? For one, I unhesitatingly admit that I entirely concur in all he asserts, and cannot forbear to express a deeper respect for one who has the courage to enunciate a truth to a class of students who are present to learn the truth. If among these are *addle pates*, who will "strain at a gnat and swallow a camel" by distorting the meaning of words to foster their own depraved tastes, be it so; such are found everywhere. To the true thinker, they will come as words of wisdom, to be applied to the proper persons and at the proper times. In a practice of forty-five years, I have repeatedly saved and greatly prolonged many valuable lives, through the instrumentality of stimulants judiciously administered. Dr. J. Milner Fothergill says: "Alcohol may be used with benefit at bed-time by those who undergo much mental activity, and whose brains are exhausted. Here some alcohol exercises a distinctly soothing effect upon the brain, and procures a sound night's rest, where without it there would be a restless, disturbed, uneasy, and unrefreshing slumber. There exists no objection to the use of alcohol under these circumstances; neither is there much probability of the habit growing, except in rare cases where there are probably other determining factors."

The late Professor Samuel Jackson, of the University of Pennsylvania, was consulted many years ago by a gentleman of my acquaintance, then in his fiftieth year, for a complication of maladies threatening early dissolution, prominent among which were vertigo, dyspepsia, languor, debility, etc., etc. His advice was, after a thorough investigation of the case, that half an hour before each meal he should take a tablespoonful of whisky in a little water. This the patient continued through the remaining years of his life, with renewed health and vigor, and lived comfortably to the age of eighty-six.

JAMES L. TYSON, M. D.

Shadyside, Montgomery county, March 18, 1885.

NEWS AND MISCELLANY.

American Surgical Association.

The Secretary, Dr. J. R. West, notifies us that the meeting of the Association will be held in the Army Medical Museum, Washington, April 21, 22, 23, and 24, 1885.

The following papers will be presented:

"The Field and Limitation of the Operative Surgery of the Human Brain," by John B. Roberts, M. D., Philadelphia.

SYNOPSIS.

I. In Cranial Fracture.—1. What conditions demand incision of the scalp? 2. What conditions demand perforation of the skull? 3. What conditions render incision of the scalp unjustifiable? 4. What conditions render perforation of the skull unjustifiable?

II. In Intra-cranial Hemorrhage.—1. What symptoms demand perforation of the skull? 2. What symptoms render perforation unjustifiable?

*Journal Am. Med. Ass., Jan. 17, 1885 p. 72.

†Lancet.

III. In Intra-cranial Suppuration.—1. What symptoms demand perforation of the skull? 2. What symptoms demand incision of the membranes and puncture of the brain substance? 3. What are the limitations to operative search for pus?

IV. In Insanity.—1. What conditions demand removal of bone? 2. How long should such operative interference be postponed? 3. What conditions render removal of bone unjustifiable?

V. In Epilepsy.—1. What conditions demand removal of bone? 2. How long should such operative interference be postponed? 3. What conditions render removal of bone unjustifiable?

VI. In Cerebral Tumor.—1. What conditions should deter the surgeon from attempting excision?

The discussion of the paper will be opened by Fellows Hunter McGuire, Moses Gunn, J. C. Hutchison, and D. W. Yandell.

"An Experimental and Clinical Study of Air Embolism," by N. Senn, M. D., Milwaukee, Wis.

INTRODUCTION.

1. On the immediate cause of death by rapidly fatal embolism. 2. History of air embolism. 3. Intra-venous introduction of air. 4. Effect of the heart and respiration on the venous circulation. 5. Aspiration of air into the superior longitudinal sinus. 6. Experiments on same. 7. Practical suggestions concerning injuries of superior longitudinal sinus. 8. Immediate cause of death after intravenous insufflation of air. 9. Intra-arterial insufflation of air. 10. Clinical study of air embolism, illustrated by cases. 11. Experiments on intravenous and intra-arterial insufflation of air. 12. Remarks on experiments. 13. Prophylactic and therapeutic recommendations.

Fellows J. Collins Warren, C. B. Nancrede, W. H. Pancoast, and Christian Fenger will open the discussion of the paper:

"Nephrectomy: Its Indications and Contra-Indications," by Samuel W. Gross, M. D., Philadelphia.

The following conclusions are presented for discussion:

I. That primary extirpation of the kidney is indicated—1. In sarcoma of adult subjects. 2. In the early stage of tubercular disease. 3. In rupture of the kidney or of the ureter; and, 4. In benign tumors.

II. That nephrectomy should not be resorted to until after the failure of other measures—1. In urinary fistulæ of the kidney or of the ureter. 2. In protrusion of the kidney through a wound in the loin. 3. In recent wounds of the kidney or of the ureter made in the performance of ovariotomy, hysterectomy, or other operations. 4. In suppurative lesions. 5. In hydronephrosis and cysts; and, 6. In floating kidney.

III. That the operation is absolutely contra-indicated—1. In calculus and otherwise healthy kidney. 2. In sarcoma of children. 3. In carcinoma at any age, unless the disease can be diagnosticated and removed at an early stage; and, 4. In the advanced stage of tubercular disease.

Fellows L. McLane Tiffany, Christopher Johnston, A. Vanderveer, and D. W. Yandell, will lead in the discussion of the paper: "Nephrolithotomy," by L. McLane Tiffany, M. D., Baltimore.

CONCLUSIONS:

1. The operation not over-dangerous. 2. Diagnosis of kidney stone not always clear. 3. Incision down to, and exploration of kidney proper.

Fellows S. W. Gross, J. W. S. Gouley, T. A. McGraw, and P. S. Conner, will lead in the discussion: "The Healing of Arteries in Man and Animals after Ligature," by J. Collins Warren, M. D.

"A study of the various pathological changes which occur in and around the vessel, from the time the ligature has been applied until the process of cicatrization has fully completed itself. The ligatured artery is invested by a protective layer of new tissue formed from the periadventitial tissue, which, if well developed, gives great security against hemorrhage until the permanent cicatrix has grown sufficiently strong. This may be likened to the provisional callus of bone. There is also an internal growth or callus formed from several sources, namely, the intima to a slight extent, the media more largely, also from cells finding their way from the periadventitia at a late stage through the retracted ends of the vessel. The thrombus is a mere passive structure, takes no part in the growth, but is protective, and affords an excellent medium for the new tissue to germinate in. When the provisional part of the internal callus has disappeared, we find remaining a cicatrix closely resembling the three coats of the artery, and affording by virtue of its peculiar structures an equally effective resistance to the pressure of the blood-column. The ligament which unites the two ends of the vessel represents in part the residue of the external callus, but also a portion of the walls of the vessel which have been absorbed during the inflammatory process. A vessel successfully ligatured in its continuity cannot, therefore, be said to have been 'ulcerated' into two separate portions, but must be conceived of as a hollow tube which has solidified into a solid columnar mass of tissues, a considerable portion of which subsequently shrinks into a cord."

Fellows N. Senn, F. S. Dennis, Moses Gunn, and Stephen Smith, will lead the discussion.

"The Immediate Cure of Fistula in Ano," by Stephen Smith, M. D., New York.

1. By the use of compressed sponge. 2. By incising the fistula and abscess, dissecting out the lining membrane of the abscess and fistula, and closing the entire wound immediately with the suture used in perineal rupture.

The discussion will be opened by Fellows John H. Brinton, David Prince, N. P. Dandridge, and Alan P. Smith.

"Etiology of Tetanus," by P. S. Conner, M. D., Cincinnati.

"The various theories that have been proposed, giving especial attention to that assuming the disease of bacterial origin, it being produced through the medium of blood rather than the nerves."

The discussion will be opened by Fellows T. G. Morton, W. S. Tremaine, J. H. Packard, and R. B. Bontecou.

"A Case of Cholecystotomy," by C. T. Parkes, M. D., Chicago.

Report of case, and general consideration of subject.

Discussion by Fellows Donald Maclean, J. Ewing Mears, and E. H. Gregory.

"Some Points in the Surgery of the Hypertrophied Prostate," by J. W. S. Gouley, M. D., New York.

1. The determination, by physical exploration, of the size of the hypertrophied prostate, and the character of the obstruction to urination. 2. The circumstances under which medicinal treatment possesses value. 3. The selection of catheters. 4. Certain accidents of catheterism, especially false routes. 5. Evacuative catheterism, its good effects and its dangers. 6. Vesical irrigations to combat cystitis, their use and abuse. 7. Prostatotomy and prostatectomy, their indications and contra-indications.

To lead in the discussion, Fellows S. W. Gross, Hunter McGuire, T. F. Prewitt, and J. W. White.

"Phosphorus Necrosis: It Causes, Treatment, and Prevention, with Reports of Cases," by J. Ewing Mears, M. D., Philadelphia. Synopsis not received.

Discussion by Fellows L. A. Sayre, R. A. Kinloch, and James McCann.

For the information of Fellows who desire to attend the American Medical Association at New Orleans, the following facts are given:

The last day of the session of the Surgical Association is April 24; the first day of the Medical Association is April 28.

Through routes to New Orleans from Washington, by Cincinnati, Louisville, and Nashville: round trip, $37.50. By Lynchburg going, Cincinnati returning, $48.00; limit of tickets, fifteen days; five days' limit of return allowed; ticket must be stamped by agent at New Orleans.

In relation to chartering a hotel or sleeping car for the round trip, the following memorandum has been received from the Pullman Co.:

"Rate for a hotel car is $65.00 per day for the entire time the car is absent, and for a sleeping car $50.00 per day, allowing a drawback, if the cars are lying over unoccupied, of $30.00 for hotel, and $25.00 for sleeping car. We would be willing to furnish the commissary at the original cost, with ten per cent. added to the original bills for handling it. We would supply conductor, cook, and sufficient waiters to handle the business. There would be no further expense so far as this company (Pullman) is concerned, if the party go and return by same route; but if they go via Danville, and return via Wilmington, or vice versa, they would have to pay the freight charges on the trucks between these points in both directions."

A sleeping car, or hotel car, will hold twenty-eight persons. If the members of the Association desire to make up a special party, and to have a car to themselves, they should notify Surgeon John S. Billings, Committee of Arrangements, Washington, as soon as possible, as such an arrangement must be made not later than April 15.

Dr. Billings will secure hotel accommodations for members who write to him for that purpose.

The approaching meeting promises to be an exceptionally interesting and valuable one, and every Fellow should be in attendance.

—Two cases of epileptiform tic have recently been reported cured by nitro-glycerine.

International Medical Congress.

The following rules and provisional list of officers of the Ninth International Medical Congress, to be held in Washington in 1887, are published by order of the Executive Committee:

Rules.—1. The Congress will be composed of members of the regular medical profession, and of such persons as may be specially designated by the Executive Committee, who shall have inscribed their names on the Register of the Congress, and shall have taken out their tickets of admission. As regards foreign members, the above conditions are the only ones which it seems, at present, expedient to impose.

The American members of the Congress shall be appointed by the American Medical Association, by regularly organized State and local medical societies, and also by such general organizations relating to special departments and purposes, as the American Academy of Medicine, the American Surgical Association, the American Gynecological, Ophthalmological, Otological, Laryngological, Neurological, and Dermatological Societies, and the American Public Health Association; each of the foregoing Societies being entitled to appoint one delegate for every ten of their members.

All societies entitled to representation are requested to elect their delegates at their last regular meeting preceding the meeting of the Congress, and to furnish the Secretary-General with a certified list of the delegates so appointed.

2. The work of the Congress is divided into nineteen sections.

3. The general meetings will be reserved for the transaction of the general business of the Congress, and for the addresses or communications of scientific interest more general than those given in the sections.

4. Questions which have been agreed upon for discussion in the sections shall be introduced by members previously nominated by the officers of the section. The members who open discussions shall present, in advance, a statement of the conclusions which they have formed as a basis for debate.

5. Notices of papers to be read in any of the sections, together with abstracts of the same, must be sent to the Secretary of that section before April 30, 1887. These abstracts will be regarded as confidential communications, and will not be published until the meeting of the Congress. Papers relating to questions not included in the list of subjects suggested by the officers of the various sections will be received. Any member, after April 30, wishing to bring forward a subject not upon the programme, must give notice of his intention to the Secretary-General at least twenty-one days before the opening of the Congress. The officers of each section shall decide as to the acceptance of any communication offered to their section, and shall fix the time of its presentation. No communication will be received which has been already published, or read before a society.

6. All addresses and papers, read either at general meetings or in the sections, are to be immediately handed to the secretaries. The Executive Committee, after the conclusion of the Congress, shall proceed with the publication of the

Transactions, and shall have full power to decide which papers shall be published, and whether in whole or in part.

7. The official languages are English, French, and German.

In the sections no speaker will be allowed more than ten minutes, with the exception of readers of papers, and those who introduce debates, who may occupy twenty minutes.

8. The rules, programmes, and abstracts of papers will be published in English, French, and German.

9. The officers of the General Committee on Organization are a president, such number of vice-presidents as may hereafter be determined on, a secretary-general, and a treasurer; and those elected to these positions will be nominated by the General Committee to hold the same offices in the Congress. All vacancies in these offices shall be filled by election.

10. There shall be an Executive Committee, to be composed of the President, Secretary-general, and Treasurer of the General Committee, the Chairman of the Finance Committee, and of four other members to be elected by the General Committee. The duties of the Executive Committee shall be to carry out the directions of the General Committee, to authorize such expenditures as may be necessary, and to act for the General Committee during the intervals of its sessions.

11. There shall be a Standing Committee on Finance, to be appointed by the president, subject to the approval of the Executive Committee. The Chairman of the Finance Committee shall be *ex-officio* one of the vice-presidents of the Congress, and also a member of the General and Executive Committees. The treasurer shall be *ex-officio* a member of the Finance Committee.

12. Presidents of the sections shall be *ex-officio* members of the General Committee.

13. The Committee on Organization of each section shall be composed of a president, such number of vice-presidents as may be deemed expedient, of one or more secretaries, and of members forming a Council.

Annual Commencement of the Jefferson Medical College.

The 60th Annual Commencement of the Jefferson Medical College was held in the Academy of Music April 2. While the large auditorium was rapidly filling, the interim was whiled away pleasantly by the music of the Germania Orchestra, under the baton of Henry Fehling, Jr. Promptly as the hour of noon approached, the faculty and graduating students filed in through a side entrance, and formed in rows on the stage, the front of which was beautifully adorned with flowers and plants. The exercises were opened with prayer by Rev. I. L. Nicholson, D. D. During the solemn words of the invocation, the students bowed in reverent attention. A selection by the orchestra followed, and then the all-important moment, which every one of the 176 members of the graduating class looked forward to with breathless interest, arrived.

Dr. E. B. Gardette, President of the Board of Trustees, delivered his address to the graduates and conducted the ceremony of conferring the degrees. The awarding of twelve prizes by Professor DaCosta, the Dean of the Faculty, took place subsequently. The names of the winners were kept entirely secret until the last moment, and all the more interest was created in this part of the exercises. There were disappointments as well as congratulations over the result, but in every instance the recipients of prizes were spontaneously applauded.

The prizes were as follows:

1. Faculty prize of $200, for the highest attainments in all departments, to Peter McCahey, of Pennsylvania.

2. A prize of $100, by Lea Brothers & Co., for the best thesis, to Andrew J. Downes, of Massachusetts; with honorable mention of the thesis of Samuel V. Able, of Pennsylvania.

3. A prize of a gold medal, by R. J. Levis, M. D., for the best report of his surgical clinics at the Pennsylvania Hospital, to Max J. Stern, of Pennsylvania; with honorable mention of the report of Frank B. Day, of Indiana.

4. A prize of a gold medal, by Thomas G. Morton, M. D., for the best report of his surgical clinics at the Pennsylvania Hospital, to Joseph D. Orr, of Pennsylvania; with honorable mention of the reports of Leonard A. Hudson, of Delaware, and John Edward Oliver, of Missouri.

5. A gold medal, for the best essay on a subject pertaining to the practice of medicine, to Max P. Van der Horck, of Minnesota; with honorable mention of the theses of T. Briggs Wright, of Kentucky, and G. Orlando Tunison, of New Jersey.

6. A gold medal, for the best anatomical preparation, to Samuel Shimavonian, of Armenia.

7. A gold medal, for the best original research in the chemical laboratory, to Andrew B. Ireland, of Pennsylvania.

8. A case of instruments, for the best original research in the Materia Medica laboratory, to Henry M. Beatty, of New Jersey; with honorable mention of the theses of John A. Dougherty, of Pennsylvania, and William H. Baldinger, of Texas.

9. A case of instruments for the best essay on subject pertaining to physiology, to Theodore G. Davis, of New Jersey, with honorable mention of the essay of George S. Brown, of Missouri.

10. A case of instruments for the best essay on a subject pertaining to surgery, to Albert C. Getchell, of Maine.

11. A case of instruments for the best essay on a subject pertaining to obstetrics, etc., to Charles F. Shollenberger, of Pennsylvania.

12. A case of instruments for the best essay on a pathological subject, to Martin P. Rively, of Pennsylvania; with honorable mention of the essay of Robert Coyle, of Pennsylvania.

The valedictory address was delivered by Dr. William H. Pancoast. In speaking of the duties of physicians, he said: "Our profession is now standing sentinel and warning the community of the impending danger of cholera for the coming year, suggesting the necessity for cleanliness and purity in cities, villages, and homes; pure water, fresh air, and clean streets. Rebreathed air is poison; impure water sometimes spreads disease as fire explodes gunpowder. Filth, idleness, and gluttony are the friends of death."

Cigar Smoking and Cancer.

Apropos of the reports (very commonly believed in this country among the public) that General Grant's condition is due to cigar smoking, we quote the following *sensible* remarks from the *Brit. Med. Jour.*, March 14, 1885:

"Whilst all who read the newspapers in any country must have learned, with regret, that the gallant general who saved his country from disunion, and guided its destinies for so many years, is suffering from a painful and deadly malady, it is very advisable that capital should not be made by a certain party out of the alleged cause of his illness. It has been distinctly reported in several journals that General Grant is suffering from cancer of the tongue caused by smoking. A little knowledge of pathology is sufficient to demonstrate that smoking cannot cause cancer, although the irritation of a pipe sometimes sets up ulceration of the lip, which, when of very long standing, may become cancerous, provided that the patient has a hereditary tendency to cancer. There is no evidence whatever that cigar-smoking causes cancer of the tongue. Mr. Butlin, the author of some of the most recent observations and statistics on cancer of the tongue, has shown that the proportion of men to women suffering from that disease is nearly six to one, but that it occurs in men who neither drink nor smoke, whilst it is as rare among women of the most masculine habits as amongst other females. Even the irritation of a broken or decaying tooth can only be an occasional exciting cause, since this condition is as common amongst women as amongst men, whilst cancer of the tongue is, fortunately, rare, out of all proportion to cases of decayed teeth. There can be no doubt that a man with a tooth irritating his tongue ought to have it removed. It is equally certain that no smoker who has a sore on his tongue ought to persist in the use of tobacco until that sore is cured. But the risk of cancer through smoking is so infinitesimal, as to be perfectly useless as an argument for the anti-tobacconists."

Jefferson College Alumni.

The annual oration before the alumni of Jefferson Medical College was delivered in the lecture-room of the college, by Professor J. W. Holland, of Louisville, Ky., on the subject "Our Personal Equations."

Dr. Addinell Hewson, the president, addressed the alumni on the occurrences of the past year, referring eloquently and feelingly to the deaths of Professor Samuel D. Gross, Dr. Ellsberg, of Dartmouth College, and Dr. Ellerslie Wallace, all alumni.

The committee on the endowment of the Samuel D. Gross Chair of Pathological Anatomy reported $5,504 in their possession, and were continued in office.

The officers for the ensuing year were elected as follows:

President—Dr. Addinell Hewson.
Vice-Presidents—Drs. R. J. Levis, William H. Pancoast, Roberts Bartholow, and Ellwood Wilson.
Corresponding Secretary—Dr. R. J. Dunglison.
Recording Secretary—Dr. T. H. Andrews.
Treasurer—Dr. N. Hatfield.

It was announced that the orator for next year would be Dr. W. H. Warder, of this city, who was called upon for a few remarks. Dr. Pancoast also spoke. After the business of the evening, a reception was given Professor Holland at the St. George Hotel. There was a general gathering of the doctors. A collation was disposed of, and speeches were made by various noted men in the profession.

Suspicious Cases of Asiatic Cholera.

At a meeting of the State Board of Health of Kentucky, held March 16 and 17, at Louisville, the following recommendations were reported:

"The following conditions shall be held to justify a suspicion of cholera, and to require from sanitary authorities the same preventive treatment as if known to be cholera:

"1. Any case of disease resembling cholera and attended with 'rice-water evacuations' shall be reported and treated either as cholera or as a suspicious case.

"2. Any case respecting which reputable and experienced physicians may disagree as to whether the disease is true Asiatic cholera or not, shall be reported and treated as suspicious.

"3. Any case rumored to be cholera, and respecting which efforts are made to conceal its existence, full history, and true nature, shall be reported and treated as suspicious.

"4. Any notable and exceptional increase in the number of cases of, and of deaths by, such bowel disorders as cholera morbus and diarrhœa, shall be promptly reported."

Therapeutic Notes.

Platt's Chlorides.

With the approach of summer, and of a summer in which we are threatened with Asiatic cholera, disinfectants must occupy a prominent position. Of these, we have met with none that seems more effective than "Platt's Chlorides." It rapidly destroys offensive odors, and counteracts the development of germ life. Whether for use in the sick-room or the purposes of general household disinfection, it is a cheap, cleanly, and efficient agent.

Horsford's Acid Phosphate.

A nerve stimulant without depressing reaction cannot fail to be appreciated in this nervous nation of ours. Such a preparation is the Acid Phosphate of Professor Horsford. In great heats, in exhausting diseases, in the languor of convalescence, and in the prostration following alcoholic and other excesses, we have seen it employed with immediate and gratifying good results. It is, moreover, palatable to the taste, and agrees with the most sensitive stomachs.

Rhode Island Medical Society.

At the recent quarterly meeting of this Society, held at Providence, March 19, the following papers were read: "Enteric Fever Occurring in Pregnancy," by Dr. Robert F. Noyes, of Providence; "Report of a Case of Pyosalpinx," by Dr. George W. Porter, of Providence; "Rachitis," by

Dr. B. R. Lymonds; "Cancer of the Intestine," by Dr. E. B. Smith; "Fatal Case of Embolism of the Pulmonary Artery," by Dr. J. S. Hunt.

The following delegates to the next meeting of the American Medical Association were elected: Drs. H. Canfield, J. W. Sawyer, O. C. Wiggin, A. G. Browning, G. H. Eldredge, F. B. Fuller, Benjamin Greene, A. Ballou, George Kenyon, Job Kenyon, H. G. Miller, Charles O'Leary, G. A. Pierce, Anita E. Tyng, of Philadelphia, H. Terry, S. Hunt, W. E. Anthony, and W. J. Burge.

Professional Secrets.

The *Lancet* says very truly: "Ought the medical adviser of a patient to betray the secrets confided in him? Without hesitation or reserve, we say 'No,' in so far as those secrets *are confided by the patient*. For example, the manner in which a patient contracted a particular malady, and the errors of life that led to it, being confided by the patient, are matters communicated in confidence, and that confidence ought not to be abused. No court of law can exercise any legal right to extort such secrets. Meanwhile the fact that the patient suffers, or has suffered, from a disease of body or mind, is not a subject of communication. The medical practitioner diagnoses the disease, and we do not think that such facts are 'secrets,' although no honorable man would mention them unless compelled to do so."

Feeling against Foreign Medical Students.

From a foreign exchange we learn that the animosity that has long since been brooding between the French and Germans appears to have extended to all foreigners, especially the English and Americans, and the spirit of exclusiveness on the part of the French even manifests itself in the medical profession. The Paris Municipal Council, however, decided at its last meeting, by forty-one votes against two, that foreign medical students who have taken their inscriptions at the Faculty of Medicine will continue to be admitted as heretofore, as internes or externes of hospitals, but for the functions of hospital physician or surgeon, or for the prosectorate, the candidates will have to be naturalized.

Official List of Changes of Stations and Duties of Medical Officers of the United States Marine Hospital Service, for the week ended March 14, 1885.

Bailhache, P. H., surgeon. Detailed as President Board of Examiners, March 10, 1885.

Purviance, George, surgeon. Detailed as member Board of Examiners, March 10, 1885.

Austin, H. W., surgeon. Detailed as Recorder, Board of Examiners, March 10, 1885.

Items.

—In the *Brit. Med. Jour.*, Dr. W. F. Smartt reports a case of bullet-wound involving right lobe of liver, extraction, recovery.

—Dr. Weber, of Darmstadt, has used apomorphine, in doses of one-twelfth of a grain three times a day, in chronic asthma, with success.—*Chi. Med. Journal.*

—We understand that *The Index Medicus* is to be continued under the same conditions as heretofore, under the auspices of the publishing house of Parke, Davis & Co.

—Prof. Lucæ died recently at Frankfort-on-the-Main. His anatomical and anthropological works achieved much for the advancement of science, and rendered his name widely known.

—It is said that Dr. Koller, the discoverer of the anæsthetic properties of cocaine, has recently fought a duel. His antagonist, one of Billroth's assistants, received a wound that may prove fatal.

In the *Lancet*, March 14, 1885, Mr. Rushton Parker reports a case of compound dislocation of the elbow-joint, with division of the main artery and vein, healed with restoration of all movements.

—Thallin, the new antipyretic, is found by Dr. C. Alexander to be better than kairin, but not so active as antipyrin, over which latter it has only the advantage of smaller dosage and more agreeable taste.

The *Indian Medical Gazette* says: "As in England, *melanotic cancer* is an ordinary cause of death in Bengal among gray and white horses. We can scarcely drive through Calcutta without seeing animals having the characteristic globular tumors beneath the skin."

—Dr. Hérard, physician to the Hôtel Dieu, and Dr. Bernutz, physician to the Charité Hospital, having attained the limit of age for hospital physicians, have been placed on the retired list, and the title of honorary hospital physician has been conferred upon them.

—During the last few months practitioners in Glasgow have had an opportunity of studying two very typical cases of leprosy, in which the signs of all the varieties of the disease were manifest—the tubercular, macular, anæsthetic, and ulcerating forms. At one of the societies also the leprosy bacillus has been exhibited.

—At a meeting of the Glasgow Philosophical Society, Prof. McKendrick and Mr. J. J. Coleman gave an account of some recent experiments on the effects of low temperatures on the putrefactive process and on vital phenomena. They found that the continued exposure of putrescible fluids to a temperature of 120° below zero did not prevent putrefaction, showing that the micro-organisms causing putrefaction are not killed even by this extreme cold, a temperature probably lower than any prevailing in the Polar regions, so that micro-organisms may exist even there. They hoped to continue their experiments with an atmosphere at a temperature of 150° below zero.

—The following case, illustrating the effect of cocaine is taken from the *Wiener Medicinische Wochenschrift*. On December 25 last, Dr. Weiss, of Vienna, was called in to Professor S., who had scalded his eyes, forehead, nose, cheeks, and upper lip, owing to an explosion of the apparatus during an inhalation; pain was very severe. He first ordered linen soaked in oil, to be laid on, and oiled bandages on the top of these. Then he ordered the application of carron oil and a 2 per cent. solution of hydrochlorate of cocaine. As soon as the scalded spots were painted with the above named solution, the pain disappeared at once, and did not return.